"Authorization is hereby given to dispense the Generic or Chemical equivalent
ss otherwise indicated by the words - MEDICAL NECESSITY"

ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12/8	1130	4 PSB to 15 OOB to chair Noted JHWilson RN [illegible] RN Summers 23284
12/8	98 1850	12° Chart ✓ JHWilson RN / R. Brutscher RN
12/8	2400	500 cc bolus of NS x 2 V.O. Dr. Nguyen / R Brutscher RN
		R. Brutscher RN
12/9	0700	12° Chart ✓ R Brutscher RN / [illegible]

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

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ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

1014

96 92549 0 9367
WALTER ,KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

ORDERED DATE	ORDERED TIME	**ORDERS** Use Ball Point - Press Firmly
12/08/98	0800	CBC Chem 2 in am
12/18/98	0700	12° Chart ✓ JRAllison RN
12/19/98	1430	12hour urine for UUN q SAT 1730→SUN 0530 Serum Prealbumin q Sunday v.o. Dr Corcoran by MC Dunford RD 22117
		Noted JRAllison RN

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

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HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

1014

ALLERGIES: ☐ NKA ☐ YES

DRUG: ______

OTHER: ______

WT: ______ kg. HT: ______ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
12-7-98	845	① ↓ SIMV rate to 6 (done by MD)
		② ↓ FiO2 to 30% (done)
		③ W to D ~~Hem~~ dressing changes tonight
		④ wean to CPAP if tolerated [signature] 23120 (NGUYEN)
		[signature] 12/7/98 0915
12/7/98	1415	Tylenol 650mg PR/elixir Q 4° prn T > 38.5
		V.O. Dr Talati / [signature]
12/7/98	1642	Rest on SIMV 8 + 4 from 12midnight to 5-am 12/7
		ABG & Mechanics on CPAP 5 AM 12/8 [signature] 23190
		[signature] 12/7/98 1700
12/7/98	1900	12° cc [signature]

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

431641 (6/95)

"Authorization is hereby given to dispense the Generic or Chemical equivalent
ess otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: _____

OTHER: _____

WT: _____ kg. HT: _____ cm.

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WALTER , KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	TIME	**ORDERS** Use Ball Point - Press Firmly
12/6/98	2000	ICU Admission Current Vent settings VT 900 SIMV 10 PS 15 +5 Tidal Vol Telemetry
12-7-98	0845	MS 2-10 mg IV Q 2-4 PRN pain Ativan 2-4 mg IV Q 2-4 PRN agitation V.O. Dr. Sumner / Arrugam
12/7/98	0700	12° ce Sumner / Arrugam
12/7/98		D d/c VT replacement. dated 12/8 Sumner 12/7/98 0900

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

HERMANN HOSPITAL

Physician's Orders

Walter, Kenk

1014

Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words-MEDICAL NECESSITY

ALLERGIES: ☐ YES ☐ NO

DESCRIBE:

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point-Press Firmly
4/7/18	0700	

Electrolyte Replacement

Disregard all protocols if patient has renal failure, is on dialysis, or has a creatinine clearance <30 ml/min.
Please fill in the electrolyte level and check the appropriate box.
Patients LBW= _____kg

Magnesium Serum magnesium level: _____mEq/L
Magnesium level 1.0-1.7 mEq/L
☐ Magnesium Sulfate 0.5 mEq/kg (LBW) in NS 250 ml infused IV over 24 hrs x 3 days.
Recheck magnesium level in 3 days.
Magnesium level < 1.0 mEq/L
☐ Magnesium Sulfate 1mEq/kg (LBW) in NS 250 ml infused IV over 24 hrs x 1 day, then 0.5 mEq/kg (LBW) in NS 250 ml infused IV over 24 hrs x 2 days.
Recheck magnesium level in 3 days.
If patient has gastric access and needs a bowel regimen,
☐ Milk of Magnesia (MOM) 15 ml q 24 per gastric tube (NG,OG, PEG). Hold for diarrhea.

Phosphate Serum phosphate level: _____mg/dl
Phosphate level 1.0-2.5 mg/dl:
☐ Tolerating enteral nutrition: Neutra-Phos 2 packets q 6 h per gastric tube or feeding tube.
☐ No enteral nutrition: $KPHO_4$ or $NaPHO_4$ 0.15 mMol/kg (LBW) over 6 hrs x 1 dose.
Recheck phosphate level in 3 days.
Phosphate level < 1.0 mg/dl:
☐ Tolerating enteral nutrition: $KPHO_4$ or $NaPHO_4$ 0.25 mMol/kg (LBW) over 6 hrs x 1 dose.
Recheck phosphate level 4 hours after end of infusion. If <2.5 mg/dl, begin Neutra-Phos 2 packets q6h.
☐ Not tolerating enteral nutrition: KPHO4 OR NaPHO4 0.25 mMol/kg (LBW) over 6 hrs x 1 dose.
Recheck phosphate level 4 hours after end of infusion. If < 2.5 mg/dl, then KPHO4 or NaPHO4 0.15 mMol/kg (LBW) IV over 6 hrs x 1 dose.

Calcium Serum normalized ionized calcium level: 3.84 mg/dl
Normalized calcium level <4.0 mg/dl:
☐ With gastric access (NG, OG, PEG) and tolerating enteral nutrition:
Calcium carbonate susp 1,250 mg/5 ml q6h per NG, OG, or PEG
Recheck ionized calcium level in 3 days.
☑ Without gastric assess or not tolerating enteral nutrition:
Calcium gluconate 2 gm IV over 1 hr x 1 dose.
Recheck ionized calcium level in 3 days.

Potassium Serum potassium level: 3.5 mEq/L
Serum potassium level <4.0 mEq/L:
☐ Asymptomatic, tolerating enteral nutrition: KC1 40 mEq per enteral access x 1 dose.
☒ Asymptomatic, not tolerating enteral nutrition: KC1 20mEq IV q 2h x 2 doses.
☐ Symptomatic: KC1 20 mEq IV q1h x 4 doses.
Recheck potassium level 2 hours after end of infusion. If <3.5mEq/L and asymptomatic, replace as per above protocol.

Date	Time	Physician Signature	Physician Name(Print)	Beeper Number
12/7/18			Hurwo	23281

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

435720

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - **MEDICAL NECESSITY**"

ALLERGIES: ☐ NKA ☐ YES

DRUG: ______________________

OTHER: ______________________

WT: ________ kg. HT: ________ cm.

HERMANN HOSPITAL #9

Physician's Orders

96 92549 0 9367
WALTER ,KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

1014

ORDERED DATE	TIME	ORDERS — Use Ball Point - Press Firmly
12/7	5AM	1) Admit to STICU (Dr. Duke)
		2) S/P GSW to Chest, Abd.
		3) Diet NPO
		4) IVF = LR at ~~[illegible]~~ 140cc/hr.
		5) Labs ABG / CBC / Chem 7 / LFTs / Amylase PT/PTT, Lipase upon arrival.
		6) H+H q6hrs x4
		7) Call HO c T>101.5 RR>35<10 SBP<90 >180
		8) CXR now + qAM
		9) Cefoxitin 2gms IV q6hrs x 2days
		10) ~~[illegible]~~ Call HO c UOP <20cc/hr x2
		11) Vitals q1hr c EKG, Pulse Ox
		12) Sucralfate 1gm PO/NGT q6hrs
		13) (B) LE SCDs c TED Hose
		14) Vent per ICU
		15) ~~[illegible]~~ CT to 20cm H2O suction
		[signature] 2477
12/7/98	5:45	MSO4 8mg } IVP now
		Ativan 4mg }
		VO-Dr Sumner / [signature]

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

431641 (6/95)

MEDICAL RECORDS

"Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words - MEDICAL NECESSITY"

ALLERGIES: ☐ NKA ☐ YES

DRUG: ____________

OTHER: ____________

HERMANN HOSPITAL

Physician's Orders

96 92549 0 9367
WALTER , KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

1014

WT: ________ kg. HT: ________ cm.

ORDERED DATE	ORDERED TIME	ORDERS — Use Ball Point - Press Firmly
	12/7/98	300 cc bottle Tri citrate x 1
	0110	replace for used.
		noted [illegible]
		[illegible signature] MD

PLEASE INCLUDE YOUR BEEPER OR PHONE NUMBER WITH YOUR SIGNATURE

431641 (6/95)

Hermann Hospital
TRAUMA / STICU PROBLEM LIST

Attending: Duke

Admit Date: STICU: 12/7 **Hospital:**

D/C Date: STICU: **Hospital:**

DIAGNOSIS/ PROBLEM	PLAN &/or PROCEDURE PERFORMED & DATE	RESOLVED YES / NO	CONSULT (If applicable)
GSW to Liver	Exp Lap → Ligation of Hepatic Artery Cholecystectomy		Service: Trauma Attending: Duke Date: 12/7/98
GSW to Abdomen (R) Chest // Pneumothorax	(R) CT		Service: Trauma Attending: Duke Date: 12/7/98
			Service: Attending: Date:
			Service: Attending: Date: 12/22/98
			Service: Attending: Date:
			Service: Attending: Date:
			Service: Attending: Date:

Consultant's Report

HERMANN HOSPITAL

Cons Rep

1023

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

TO: (Consulting Physician) Procedure team (Consulting Service)

FROM: Duke (Attending Physician) trauma (Attending Service)

RE: (Reason for Consultation Request)

12/12/98

24 yo BM s/p mult GSW to chest / abd 12/7/98 → damage to liver, now on vent c leukocytosis, referred by primary team for NJT for enteral access

from chart review:
- PMH: none
- PSH: trauma lap above c hepatic artery ligation
- Allergy: NKDA

PE: NEURO - awake, FC
CHEST - coarse BS (R) > (L), intubated
CV - tachy but regular, no murmur
ABD - soft, mod dist, open midline wound, obese
EXT - ø edema (B) LE

LABS: 144 | 107 | 21 / 4.2 | 31 | 6.4 < 118 — 51 / 159; 67 / 515; 1.4/1.1; mg 2.0; LCT 55; 15.3 > 9.0 / 28.0 < 455 (2 PRBC 7.7); 12/7 PT 14.2, PTT 33.7

A/P: 24 yo BM c mult GSW to chest + abd requiring enteral access → will place NJ tube, the procedure c its risks / benefits / alternatives was d/w the pt, he appeared to understand and asked thoughtful questions and wishes to proceed, informed consent obtained, pt seen + examined c Dr Marvin

12/16/98 24 yo BM s/p GSW the (liver). now w/ resp distress / prolonged ventilation.
neuro - [illegible]
ABD - soft. [illegible]
chest - CTA
CV - [illegible]

(A): [illegible]
(P): NJT placement

(Consultant's Signature) 2429 Wood Page 1

[illegible]
6 CS [illegible]

ᴬdditional space is required, please use another sheet.)

DISTRIBUTION: WHITE - Medical Records
CANARY - Attending Physician
PINK - Consulting Physician

434464 (10/95)

Radiology Consultation Notes

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date: 12/7/98 (✓) Inpatient: STICU ( ) Outpatient
Type of Imaging Procedure:
Diagnostic/Clinical Information:

PATIENT ASSESSMENT

Time of arrival: NPO Since: last PM.
Vital Signs (Baseline): B/P: P: R:
LAB VALUES (if applicable) O_2 SAT
BUN: CREAT: PT: PTT: Other:
Age: Weight: Height:
Allergies: NKDA

ID Bracelet: Yes ☑ No ☐
Consent: Yes ☑ No ☐
Prep Skin Yes ☑ No ☐ Prepsite:
Betadine ☑ HIB/CLENS ☐ Other ☐
Pregnant: Yes ☐ No ☑ LMP:

Contrast Type: Amt:
PRIOR CONTRAST ☐ No ☐ Yes
CONTRAST REACTION ☐ No ☐ Yes

HISTORY:

RESPIRATORY
- ☐ Asthma
- ☐ COPD
- ☐ SOB

See H&P

CARDIOVASCULAR
- ☐ CHF
- ☐ ANGINA
- ☐ HTN
- ☐ MI
- ☐ Murmur/Arrythmia

Nuerologic
- ☐ TIA
- ☐ CVA
- ☐ Seizure

Liver/Metabolic
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Bleeding Problems
- ☐ Diabetes

Other serious illness? List:
Current Medication:

Teachings:	Written	Verbal	Flouro Time:
Pre Procedure	☐	☑	
Post Procedure	☐	☑	
Post Sedation	☐	☐	

Comments:

Physical Exam:

	Pre-	Post-
TIME/SIGNATURE	R.	
NEUROLOGICAL	intact	
Activity: Able to move 4 extremities	✓	
Activity: Able to move 2 extremities		
Activity: Able to move 0 extremities		
Level of Consciousness: Alert, awake	✓	
Level of Consciousness: Drowsy, but easily aroused		
Level of Consciousness: Aroused by stimuli		
Level of Consciousness: Stupor, aroused by vigorous continuous stimuli		
Level of Consciousness: Responds to pain only		
Level of Consciousness: No response to pain		
SKIN	w/d	
RESPIRATORY: Respirations	unlabored	
RESPIRATORY: Breath Sounds	/	
RESPIRATORY: O_2	@ 5Lnc	
CARDIOVASCULAR: EDEMA	1+ generalized	
CARDIOVASCULAR: APICAL/RADIAL PULSES	V=A	

CARDIOVASCULAR: PULSES	Ext.	Pulse: Femoral	Dorsal Post	Pedis Dictal
PRE	R			
	L			
POST	R			
	L			

DRSG/INCISION Skin Post Op: ☐ Bandaid ☐ Tegaderm ☐ Sutured ☐ Steri Strip

PUNCTURE SITE(S): Bleeding Absent ☐ Present ☐ Swelling Absent ☐ Present ☐

Report called by: N. Justice RN Time: 1155 Report given to: Renee
Dismissed to (✓) room # STICU-19 ( ) home: accompanied by: STICU-RN
Dismissed per ( ) W/C ( ) Stretcher (✓) Bed ( ) Ambularoty Discharged Time:
Transportation called at: 1155

435140

Radiologist	COHEN/ABSHER/THOMPSON	Vital Signs					NURSES NOTES
Nurse	M. JUSTICE	Time	B.P.	O2 Sat	Heart Rate	Resp Rate	1100 - Pt brought to
Technologist	H. DUNKIRK	1115	147/85	96	119	18	angio suite, placed
MEDICATION ADMINISTRATION		1130	147/83	97	114	18	on table. ECG, SPO2
TIME / DRUG NAME	DOSE/ROUTE	1135	151/86	95	111	18	NIBP sensors placed.
1130 Versed	1mg IV	1140	142/84	96	111	18	pt's (R) upper chest prepped
1130 Fentanyl	50mcg IV	1145	147/84	97	114	18	& draped in usual
		1150	153/87	96	111	18	sterile fashion.
							1125 Procedure started
							by Dr Cohen, Dr Absher
							& Dr Thompson.
							1130 - Versed / Fentanyl given
							for sedation.
							- Procedure completed
TIME / IV FLUIDS	SITE/CONDITION						sterile drsg applied
							to site. drain connected
							to drainage bag. ordered
							x-ray taken
							[signature]
INTAKE =							
OUTPUT =							

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WALTER ,KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	
STICU	STICU Admit
12/7/98	Pt. is a 24yo BM s/p GSW to abd/chest: Pt. underwent
0630	Exploratory Lap & ligation of common Hepatic art., cholecystectomy,
	Lower liver hemorrhage controlled, (Hemorrhage controlled & Pringle
	maneuver)
	PMH: ?
	Meds: ?
	Allergies: NKDA
	Neuro: Sedated s/p Exploratory Lap Ativan / MSO4
	Pulm: (B) Crackles SIMV 10/23 / Vt 900 / PEEP 5 / PS 15 / Ps Vt 310
	7.29/41/141/20/-6 /97.1
	CV: RRR 101/67 HR 125 MAP 115 Hgb 12.6
	Abd: soft, tympatic, (+) BS
	Nutrition: NPO
	F/E/N: I LR @ 140 cc/hr
	O 300+ cc Ur 40 (R) CT 150
	ID: Tm 37.2 WBC 16.5 Ceftriaxone #1
@0535	13.4 / 16.5 / 87 / NDiff Ca I 3.54 @ 0028 137 / 103 / 14 / 123 PT / PTT / INR
	3.5 / 24 / 1.5 / 118 / 44 / 0.8
	A/P - ↓ Ca, replace
	- ↓ K+, replace
	Kevin Walter 23247

Date of Service	
Date & Time	Trauma
12-7-98	Pt s/p GSW - Lt clavicle, Rt abd, Pt chest s/p CT on Rt, OR → Hepatic Art Lig, Cholecystectomy Now post Op Arousable, open eyes, moves voluntarily, follows commands Sinus - 101/100/57/15 → 7.29/41/141 Cont BS (B) CV - stable MAP 115 P tachy 120-130's Abd - ↓ open wound - for delayed closure Ext - (+) pulses, moves all H/H = 13/40 A/P - Pt stable Slow Wean Vent Cont Abx V H/H this evening Δ during BID 24796

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WALTER ,KEVIN
~~BM Age~~ 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	Pre-op Note
12-7-98	24 y/o M - multiple GSW. Hypotensive. Rt hemothorax. C.T.
	placed. By himself surg - lost 1300 mL. Plan to OR - expl lap
	possible thoracotomy
	Duke
12-7-98	Brief op Note
2400	Pre-op Dx: multiple GSW chest/abd; Rt hemothorax
	Post Dx: GSW chest, hemothorax (Rt); GSW liver (medial lt lobe)
	Op: expl. lap. ligation of common hepatic artery. Cholecystectomy)
	Op Fnd: massive arterial hemorrhage GSW @ medial area of
	lt lobe, hemorrhage controlled c Pringle maneuver, @
	subcut GSW transverse extraperitoneal lower abd.
	~~[illegible]~~ cessation of c.t. bleeding when liver hemorrhage
	controlled
	Anes: Gen
	Surg: Duke
	Assist: Beyers
	EBL: 2000 mL C.T.; 1000± abd.
	Cond: critical
	Duke

Date & Time	Date of Service
	Nursing admit
12-07-98	in from OR 24 yr ♀ S/P Exlap c̄ multiple
05	GSW). pt - Anesthetized, BP stable on ST [illegible]
	admission care done, placed on ventilator.
	DR Sumner here & received orders. [illegible]
12-7-98	Nursing Summary 7P-7A
0702	Neuro: awake MAE's & follow command
	medicated c̄ MS (ativan) for pain + agitation
	c̄ adeq - relief. Skin: Tmax 37.4 bullet
	holes c̄ sm sanguinous drainage on Ⓛ shoulder
	& Ⓡ posterior chest. CV: in ST ø ectopics
	BP stable. periph pulses palpable. Resp:
	no vent Δ's Sat 98-99%. Spont - Resp. noted
	Ⓡ chest tube drainage moderate blood.
	dsg reinforced. GI: NGT drainage moderate
	greenish. abd obese c̄ +BS @ present
	GU: urine output. ~~[illegible]~~ adeq. [illegible]

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WALTER ,KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
12/7/98	Stern # S/P GSW x3 (1) neck c̄ lodged in clavicle
	(2) ABD s̄ peritoneal entry
	(3) (R) chest c̄ Diaphragm / liver injury
	Exit (R) flank
	S/P liver repair c̄
	hepatic artery ligation, (R) hemothorax c̄ CT drainage
	NEURO: Sedated. S/P OR on Ativan / MSO4
	will open eyes, FC MAE.
	Resp: Crackles IMV 10/23 / 900 / 40% / +5 / PS 15.
	PIP 47 PPl 35. PS TV 310
	ABG 7.29 / 41 / 141 -6.
	CV HR 133 rapid regular Hgb 12.6
	MAP 89.
	ABD: Soft, ABsent BS
	FEN: LRC 140cc/h Lytes (R) CT 190cc
	I/O UO 300 cc
	EXT: ∅ DVT prophylaxis
	ID WBC 16.5 Cefoxitin 1/2 prophylactically
	Tmax 38.4
	Plan: WEAN Vent.
	DVT / GI prophylaxsis.
	Aerdomine c̄ ↑ Dose depend Continue IVF, ✓ Hgb.
	antifortion
	[signature]

Date & Time	Date of Service
12/7/98 1810	STICU Nurses Note 7A-7p
	Received pt from off going RN. neuro: Awake, Follows commands ō MAE. Resp: Attempting to wean. Currently on CPAP, PS10, Peep +5, RR 28-34. SaO2 ≥ 98%. (R) CT draining bloody drainage. Dsg D/I (R) + (L) PTs. ST 130's. VS stable. Tmax 38^6. Given Tylenol PR. I/O > 40cc/hr. Medicated ō Ativan/MSO4 for pain/sedation. Continue present plan of care — [signature]
12/7/98	Nurse Liaison Note
	Spoke ō pts mother condition update given concerns/questions addressed. Pts protect name changed to Jane Wilford family aware. Will cont to keep family updated + address concerns/questions [signature]
12-7-98 2350	Nursing Summary — Care Plan Reviewed —
7P-2300	Complete assessment unchanged, as charted at beginning of shift. Family here to visit. c/o pain. MSO4 IV administered.

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
	Nursing Note: Nurse awake, alert, oriented x3
12/8/98	follows all commands. C/o tachycardia
	BP stable 140-160 pulses palpable. Hgb 10.0
	Pulm: RR ↑ 40 but no desaturating
	c/o of shortness of breathing. Medications
	[illegible]; possible extubation. Few coarse
	breathsounds. Skin [illegible] wound
	[illegible] healthy tissue moderate amount of
	sanguineous drainage - [signature]
12/8/98	STICU HD#1 POD#1
10:05	Neuro: Pt. awake, alert, MAE, PERL
	Pulm: CTA (B) CPAP FIO2 30% Rate 45/PRSV 430 /PS 10
	7.43/44/77/29/5/95% S_pO_2 100%
	CV: RRR 143/81 HR 134 MAP 112 Hgb 10.7
	Abd: soft, nipple, ND, obese
	Nutrition: NPO
	F/E/N: I 3482 / O 2632
	Ur 1777
	CT (R) 355
	ID: Tm 38^5 WBC 13.5 Cefoxitin
	141 | 108 | 15 / 146; 5.0 | 25 | 1.1 — 13.5 X 10.7 / 101 / 32.3
	A/P: ↑ Temp, ↓ WBC
	[signature]
	Hurtado 2524

Date of Service	
Date & Time	Nutrition Note 14-8-98
IMNT	ONPO Day 2
	24y.o. ♂ s/p GSW Abdomen + chest, hepatorraphy, HTX, hepatic artery repair, cholecystectomy
	HT, 182 cm WT 143 lbs Adj 98 lbs
	A ESTIMATED NEEDS (BEE X 1.2) 2625 Kcal, 171 gm Protein to maintain optimal N balance and heal wounds. Meets criteria for immune enhancing enteral product.
	P 1. NJ tube
	2. Impact 105 cc. qh
	3- Nutrition labs q Sat.
	M°Dougan RD
	22117

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	SICU staff, HD#2 POD#1
12/8/98	Neuro: Awake, Alert FC GCS 15T
	Resp: CTA (B) CPAP/PS 30/0 RR 45
	7.43/44/77 95% — c SVT 400ml
	CV HR 130 regular MAP 108 Hgb 10.7
	ABD: soft ND, ⊘BS. ⊘BM.
	FEN - I/O 3.4/2.6 urine 1777
	(R) CT 355cc Gtes :am[illegible].
	ID Tmax 38.8 Cefoxitin #2/ Empiric ABD coverage
	WBC. 13.5
	Plan: needs ambulation
	↑PS to Augment TV, ↓RR.
	OOB to chair.
	watch ID.
	[signature]

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
	Trauma HOD [illegible]
12/8/98	
	Neuro [illegible] MAE FC
	Pulm CPAP // 7.43/44/77/25 [illegible] 95%
	CV ~~[illegible]~~ Rate 133 [illegible] 10.7
	Abd soft supple ND [illegible]
	[illegible] 3.4/2.6
	[illegible] 355
	Tm 38.5 WBC 17.5 [illegible] ×2
	- ↑ PS
	- [illegible] [illegible] [illegible] ✓ [illegible]
	- OOB // [illegible] [illegible] [illegible] [illegible]
	[illegible signature]
	[illegible]
12/8/98	Nursing Note 7A - 7P
1600	Vitals: Tmax 39.0, HR 130-140's, RR 25-35, BP 150's / 80's
	Neuro: A/O x3, PERRLA 2+, MAE c̄ symmetrical strength.
	Pt writes notes to communicate.
	CV: ST s̄ ectopy 130's, BP as above. 2+ pulses x all
	extremities. PIV in (R) AC c̄ LR @ 140cc/°, (L) wrist HL.
	Knee high TED hose et SCDs on.
	Resp: Remains intubated, current vent settings : 30% CPAP
	PEEP 5 PS 15. Lungs clear, diminished in bases.
	Suctioning scant amt bloody secreations. (R) lateral CT

Date of Service

Date & Time	
	to 20 cm sxn c̄ mod. amt serosang. drainage.
	GI: OGT clamped. ⊖ BS x 4. Abd soft, rounded. Pt denies pain x̄ incisional, well controlled c̄ MS04. Midline abd dressing D/I, RLQ, LLQ dressings D/I.
	GU: Foley in place c̄ good urine output.
	Skin: Ⓛ posterior shoulder dressing D/I, R lower back dressing D/I. No signs of breakdown noted.
	Psychosocial: All cares explained to pt who nods understanding. Family at bedside et updated. Questions answered, reassurance given. Family appears close et supportive. JHudson RN
	Nursing Summary 7P-7A
0700	Neuro: PERL, awake & alert, follows commands. Resp: CPAP, 30%, P.5 PS 10, RR 38. CV: ST @ 140, BP stable. GI/GU: no BMs, u/o adequate. Tmax: 39.1. Family: At bedside, mother & wife & sister visited & updated. Pain: MSO4 & Ativan PRN. R Bulochnik RN

430016 (Back Page)

HERMANN HOSPITAL

Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	SICU HD# 3 POD 2
12-9-98	Neuro - Awake, FC, MAE, writing Notes
	Pulmo - CPAP ~~30~~ 5 / PS 15 / RR 30 / FiO2 30
	ABG 7.45/45/76/31/8/94.1
	CV - 158/78 130-140's MAP 94 Hgb 9.5 (10.7)
	Reg Rhythm tachy
	Abd - soft ND, BS present.
	FEN - 4614 / 2025 UO - 1855 CT 220
	ID 39.0 WBC 13.5 on 12-8-98
	A/P 24 y/o BM s/p GSW Neuro - Awake, Pulmo
	stable, CV - tachy → 2 500 cc Bolus with No
	Δ in HR
	[signature] MS4

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Pt. H&P / Prog Notes

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WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

Date & Time	Date of Service
12/9/98	Trauma S/P GSW to chest / Abd Resp - stable on CPAP : 7.45/45/76/31/3/94% CV - 138/85 tachy 130's Abd - soft, appropriately tender @ BS Temp - 39.0 @ Abx WBC 13.5 yesterday A/P - PT febrile Will √ CBC d/p in AM Will ~~spike~~ culture today Re-check Hct in AM If continues to spike CT abd

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Pt. H&P / Prog Notes

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WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

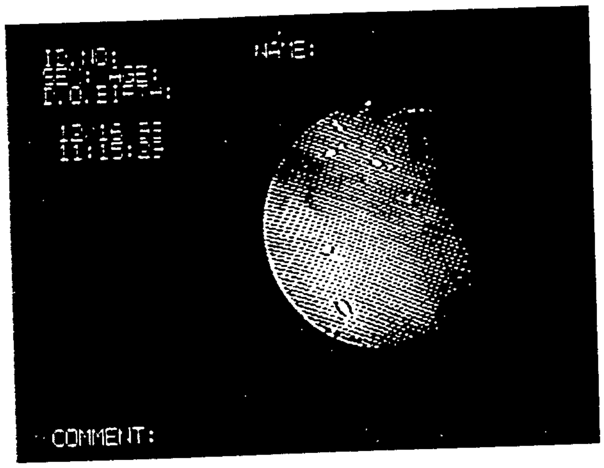
Date & Time	Stim Staff HD#3 POD 2
12/9/98	Neuro GCS 11T. Awake, Alert. FC
	Resp - CPAP/PS 5/15 RR 30's. Mechanics RR 29 TV 205
	PS Volume 250-400ml. 7.45/45/76. VC 570 NIF -70.
	CV: HR 133 sinus MAP 101 Hgb 9.5 (10.7)
	ABD: soft c active BS.
	FEN: I/O 4.6/2.0 urine 1.8L
	Lytes ø CT 220cc ø air leak
	ø nutrition NGT ø
	ID Tmax 39° WBC ø ABx.
	Plan: Needs nutrition → impact.
	Resp. mechanics still marginal c ↑ MV.
	? CT ABDomen for Fever source.
	Culture Blood/urine/sputum
	[signature]
12/10 0500	Nursing Summary 7P-7A
	Neuro GCS 11t, awake & alert, able to write needs & questions, PERL 3+ Resp CPAP 30%, P-5 PS-13, RR 25
	CV ST @ 120 s ectopy, BP stable GI/GU ø BM, BS present w/o adequate Electrolytes pending
	Tmax 39.0 - Pan cultures done today & Tylenol given c little results. Family girlfriend & step mother visited & sister called - ~~[illegible]~~ updated & verbalized understanding — K. Butcher RN

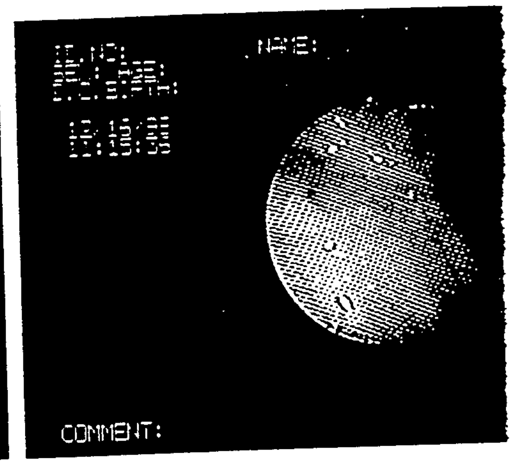
Date & Time		Date of Service
	STICU R3 Note HD# 4 POD 3	
12-10-98	N - Sleeping but rousable, MAE, FC	
	P - CTA (B), CPAP 5 PS 13 FiO2 30% Rate 36 SpO2 99%	
Meds good	7.48 / 44 / 67 / 33 / 9 / 92.7 (on CPAP)	
	CV - P124 reg MAP 90 Hb 9.6	
	ABD - protuberant, soft, NT, ØBS, ØBM (sucralfate) Ønutrition	
	Ext - TED's + SCD's (B), warm	
	FEN - I/O 3.2 / 2.7 U.O. 1.3 NG 850 ~~CT 500~~	
	141 / 104 / 14 / 119; 3.8 / 35 / 0.8	
	Tm 399 WBC 24.9 (13.5) 12/8 +BX Ø	
	Plan - ✓ CX, pt self extubated before rounds, doing well, start TF slowly, CT of abdomen in a few days, OOB to chair / H Nguyen 23120	
12/10/98 10:00 PM	Trauma POD#3 self extubated today	
	N ⇒ arousable ‖ FC ‖ MAE	
	Pulm → Face Mask ‖	
	CV → P130 MAP 102 Hb 9.6	
	ABD soft NT wound clean, dry (Ø signs of infection)	
	FEN 3.2/2.7 UOP 1.3 NG 850 CT 500 (bloody)	
	141 104 14 < 119; 3.2 35 0.8 ~~CT 500~~ 12/8 WBC 24.9 (13.5)	
	- D/C Os Y-NS ‖ ✓ DHT placement ⇒ start feeds	
	- CT of ABD in a few days if continues to spike	
	- OOB to chair	
	- CXs to be sent today	
	[signature]	

430016 (Back Page)

Date of Ser

Date & Time	





430015 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

TRAUMA/CRITICAL CARE ATTENDING NOTE - Date 12/16 Patient Wilford
Patient seen, examined, and discussed with: ✓ Trauma Team, ✓ ICU Team
Specifically reviewed plan with Dr. Wilford
Hepatic Abscess Drainage

HD # 12 System	Comment	Plan
		747/32/64
Neuro: A&A, FC		
Pulmonary: IMV=12(21)	Vt=700 PEEP=5	PS=15(500) ✓ Mechanics VE=18, ~~Sdm~~
Cardiovascular MAP=91	P=105 Hb=8.4	<T=250 — ✓ Bile ~~Contact~~
	Drain 640cc	
Abdomen: NJ Tube	↑BMx4 Stress Gastritis: ~~NI.~~ Sucralfate	✓ Cultures
I/O: 3200/3800	DVT Prophylaxis: ~~NI.~~ SCD's	
D T_m= 39° WBC= 17,400	Antibiotics: ~~NI.~~ cefepime/Gent	

Frederick A. Moore, M.D.

12/16/98	Procedure Note
	Indication: need for enteral access
	Procedure: NJ tube placement
	Anesthesia: demerol, versed, vecuronium
	Staff: Marvin Resident: Wood
	Findings: (see picture) ulcer in first portion of duodenum
	Complications: none
	pt tolerated procedure well
	12/16/98 Wood

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Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
12/16/98	Physical Therapy
1205	S - ø
	O- Pt. found supine; Pt. rec'd (B) LE PROM ex's x 15 reps all planes.
2-ex	Pt. performed PF actively (B) LE'S. Pt. rec'd (B) heelcord stretching
	X10 reps. Pt. did minimal IR/ER of (B) LE's actively x 10 reps.
	Pt. (L) supine c̄ (B) wrists restrained + rails in place.
	A- During ex's of (L) LE pt. BP remained stable @ 130-140's/70's.
	(As) therapy progressed on (R) LE pt. BP ↑'d to 150's-160's/90-1..
	Pt. followed commands if physically able. Pt. responded
	appropriately to questions. Tone in (B) LE'S (N). No redness
	noted on (B) heels.
	P- cont. PT Jim Swenson PT #22124
12/16/98	Lab addendum (Microbiology)
1530	12/13 BC E. Coli, Urine >100,000 E. coli
	12/15 BC NGTD, Urine - NG
	12/15 Body Fluid G⊕ cocci in pairs, G⊖ rods, G⊕ cocci in chains
	ø Yeast, ø MRSA
	[signature]
	Hurtado 23281

Date & Time	Date of Service
12/16/98	nursing shift summary 7A-7P RESP
1830	IMV 12 VT 800 PS PSB O2 sat. 98-100%
	CV sinus tach ē ectopy HR 100-110's
	pt becomes hypertensive when agitated
	Neuro - A+O x3 - pupils equal +
	reactive - able to move all
	extremities. GI: pt had ē BM - NJ
	placed - tube feedings to start ē
	promote @ 15cc/hr - pt tolerated procedure
	well. GU UOP > 40 cc/hr Immuno
	Tmax 38.4 WBC 17.4, Family to BS
	all questions + concerns answered
	pain controlled by morphine PRN
	Abdominal wound ē W→D dressing ē
	sterile NS + held ē ABD ↓ Montgomery
	straps ——— Robert [illegible]

430016 (Back Page)

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Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	TRAUMA HD13
12/17/98	
	N- AA FC MAE 7.45/34/76/23
	P- SIMV 12 /21 TV700 5/15 FiO2 30% P/P 31/29
	CV- P111 MAP 82 ↳500 MV 16
	Hg 8.7
	[illegible] [illegible], [illegible] [illegible] ‖
	3.7/3.4 [illegible] 3.5 [illegible]
	WBC [illegible] 23.8 (17K) ‖ Cef / Gent
	- TTFs per protocol
	- Will discuss [illegible] [illegible] [illegible] [illegible]
	[illegible] [illegible] CT 2° to biliary-pleural fistula.
	- [illegible] / [illegible] [illegible] from [illegible] [illegible].
	- OOB to chair ‖ CONT [illegible]
	[illegible signature]

TRAUMA/CRITICAL CARE ATTENDING NOTE - Date 12/17/98 Patient Wilford
Patient seen, examined, and discussed with: ✓ Trauma Team, ✓ ICU Team
Specifically reviewed plan with Dr. Byers.
HD# 13 RR=27 VE 11 L/M NIF -62

System	Comment 7.45/34/76	Vt=415 V elar=600 ⊕ cuff
Neuro: A&A, FC		Biliary → Pleural C.T= 295 Fistula leak
Pulmonary: IMV=12 (21) Vt=700 PS=15 (500) 31/29	VE 16 L/M	[illegible] (Bilirubin ≈ 8)
Cardiovascular MAP= 82	P= 100 Hb=8.7	GI Consult
	[illegible] NJ Tube →	Advance per protocol
Abdomen: Soft ⊕ B.S	Stress Gastritis: N/	Improved
I/O: 3700 / 3500 Wound clear	DVT Prophylaxis: N/	SCD's UTI
ID Tm= 38.4 WBC= 23,800	Antibiotics: N/ Cefepime/Gent	

Frederick A. Moore, M.D.

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	STICU HD 13
12/17/98	Neuro: A/A, FC, MAE
	Pulm: SIMV/12RI / 700/5/15 Sxn's Bu P/r 31/29
	7.45/34/76/23/0 /95 v 16
	Mechanics R 27/415/11.2/600/-60/+
	Course BS ⊕
	CV: P 100 MAP 82
	High 8? RRR
	FEN: I/O 3.7/3.8 Uo 3.5 Bull x ii
	4.12 / 24 NG 400 TF: Promote C
	33 CT 295 15cc's/h
	Abd softly distended Drain 160
	wound granularity ⊕ BS
	ID: Tm 38.4 WBC's 23.8 (17.4)
	Cefepime / Gent E.coli Abd/urine
	gm ⊕ cocci gm ⊖ rods fluid
	A/P ~~[illegible]~~ Cont to wean to CPAP
	Advance TF's
	? start Ag GI - will D/W [illegible]
	✓ sensitivities
	[signature] MD

Date & Time	Date of Service
12/17/98	IR WBC ↑ 23[8] up from 17[4]. Temp. 38.4 ↑ Subdiaphragmatic drain: 160cc ↓ from 640cc Fluid – gram stain Gram ⊖ cocci: Few Gram ⊖ rods Pt on Gent / Cefepime WBC continue to follow May need to CT if cont ↑ WBC ± low fluid output of drain Dalel Abbas MD 404-3670
12/17/98 INT	Nutrition Note ○ Promote 15cc qh 24 y.o. ♂ s/p GSW abd + chest, Hepatorraphy, HTX, Hepatic artery repair, cholecystectomy, Ht 182 cm wt 143 kg Adjusted 98kg A Est Needs (BEE x 1.2) 2625kcal, 171 gm Protein to Renal. P 1. Promote 110cc qh per NJ 2. Nutrition labs q SAT 3. MGA. Feed at 80% REE ± enough protein to promote ⊕ 3 – ⊕ 5 N Balance. M. Dungo RD 12/17/98

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	
	Nursing Summary 7AM- 7pm. 12-17-98.
Neuro-	No changes. MAE = strength 4/5. Follows commands, oriented person, place
CV	HR + B/P stable. ST Sectory. Rate 100-122 - systolic 110-145 dys-
Pulm	65-85. MAPS - 83-100 good pulses. Vent support decreased to
	IMV of 6 - from 12 spontaneous rate @ 24-30. Lungs coarse, moderate amt
GI.	white creamy secretions. (GU) BS(+), BM x1 liquid, TF Rate increased to
	30 cc/hr. via NJ. see Feeding Tol. sheet: to be advanced per protocol -
GU-	large cake output. Yellow + clear. SKIN - Mid abd incision open
	upper + lower part. middle part is tact c sutures. W -> D dsg.
	Wound c granulation tissue. Fam/Ig: Pt's girlfriend visited + mother
	called x 2. update given + questions answered. Myasthenia
12/18/98 0415	Nursing Summary 7P-7A: (1) Neuro: No A's, PERRL, MAE
	(2) HD: Stable BP CV; Continues c ST Sectopy. (3) FEN
	Receiving Promote @ 45 cc/o as per protocol. No
	BM, no distension. Receiving NS @ 125 cc/o
	c MgSO4 @ 10.4 cc/o. AM labs pending. U/O > 30 cc/
	(4) Skin: No skin breakdown. Mid abd wound
	c granulation tissue throughout. W -> D Dsg
	applied & secured c Montgomery Straps. (5) Family:
	Wife to bedside c questions & concerns addressed.
	(6) Infection: Receiving antibiotics as per order
	afebrile. Will continue to monitor. (7) Pain: MSO4
	10mg IV x 1 given c Ativan 4mg IV given c
	pt. resting. S. Phenergan given for c/o nausea w/
	bag reflux c sf. G. Scott RN

Date of Service

Date & Time	STICU HD 14
12/18/98	Neuro: A/A, FC, MAB
	Pulm: SIMV/4/ /700/5/15/30% v 16 P/P 35/-
	7.42/39/68/25/1/94% PSU 5-600's
	CTA (B)
	CV: P 103 MAP 104
	Wgb 84 RRR
	FEN: I/O 3.9/4.4 Uo 4.0 Drain 35
	137 / 111 / 11 / 140 4.16 2.3 NG 200 TF: Promote C
	4.1 / 25 / 0.7 3.3 CT 167 45cc's / h
	Abd soft (+) BS, wound granulating
	ID: Tm 38.5 WBC's 16.9 (23.8)
	Amp / Cefepime / Gent
	A/P: ✓ mechanics
	HD stable
	GI to start
	Cont abx
	[signature]

430016 (Back Page)

Date of Service

Your patient has been evaluated by the Respiratory Therapy Consult Service. Based on the clinical indicators derived from the following assessment, the Care plan designated below will be implemented

Breath Sounds	Breathing Pattern	Cough	Sputum Production	Mobility
☐ clear ☒ diminished BL ☒ fine ☐ coarse ☐ wheezes ☐ absent ☐ stridor	☐ nonlabored ☐ labored ☒ shallow ☐ irregular ☒ rapid ☐ mech. vent.	☐ strong ☒ fair ☐ weak ☐ absent	☐ none ☒ sm. amt. ☐ mod. amt. ☐ lg. amt. Consistancy/Color ☒ thin ☐ mod. ☐ thick pale/red	☐ ambulatory ☒ up w/ assist ☐ bed rest ☐ paraplegia ☐ quadriplegic

Mental Status	Chest X-ray	Vital Signs	Lab	Lung Volumes
☒ alert ☐ obtunded ☐ confused ☐ unresponsive	☐ clear ☐ infiltrates ☐ atelectasis ☐ pleur. effus. ☐ pulm. cont. ☐ rib fx ☒ not avail.	HR 123 RR 28 BP 153/87 Temp 102	WBC 24.9 Hg 9.6 SpO2 97	Actual PF IC VC Predicted PF IC VC

431485

RESPIRATORY CARE PLAN

Medicated Aerosol Therapy NEB MDI (IPPB) Frequency Q3'-4°

Aerosolized Medication: NS

Volume Expansion Therapy IS IDB Frequency

Bronchial Hygiene Therapy PD Perc IPV Frequency

Spinal Cord Protocol: Frequency

Oxygen Therapy FIO2 .40 LPM 12 Delivery Device AFM

Comments

cont to wean FIO2 for SaO2 ≥ 94 instruct on IS + encourage cont IPPB tx Q3°-Q4° OOB to chair (PT)

430016 (Back Page)

HERMANN HOSPITAL

Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt, 12/07/98

2014

Date of Service

Date & Time

CRITICAL CARE ATTENDING NOTE - Date 12/10/98 PATIENT Wilford

Patient seen, examined and discussed with ✓ Trauma Team, ✓ ICU Team; Specifically reviewed plan with Dr. Nagel

System	Comment	Plan
	HD #4 s/p GSW [illegible]	[illegible]
Neuro	awake, alert, respon[illegible]	[illegible]
[illegible]	self extub[illegible], toler[illegible] 100% sat	[illegible]
CV	P 130 BP 168/91	Hgb 9.6
abd	[illegible] soft, [illegible] OK, [illegible]	
FEN	3.2 / 12.7 [illegible] Cl [illegible] IV c D5 ½ NS;	
	CT - 500 cc still [illegible], [illegible] OK	NG - 850 ; still [illegible]
ID	38° WBC 24.9 [illegible]	✓ cult

[illegible], [illegible] at 10 o/L

Signature: [signature]

Christine S. Cocanour, M.D.

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	
12/11	(Nursing) Summary) 7P-7H:
0515	(Neuro) awake & alert, oriented GCS-15 PERL
	(Resp) 3L NC, RR-3's, Sats 96%
	(CV) ST @ 120 's ectopy, BP stable
	(GI/GU) (+) BM, adequate UO; Pt pulled out Dobhoff tube & NG; replaced dobhoff tube, primate on hold until KUB cleared
	(Pain) MSO4 & Ativan PRN
	Tmax 38.8 - tylenol & ibuprofen given c no results
	(Family) step mother, girlfriend, sister visited & updated - verbalized understanding
	R Butscher RN

Date of Service

Date & Time	
12/11/98	STICU HD #5 POD #4
	Neuro: AXO x3, MAE, PERL, responds to commands
	Resp: CTA (B) CPAP Rate 15 / ~~PEEP 5~~ / PS 13 FiO2 30% SpO2 97%
	~~7.48/44/67/33 /4/92.7%~~
	CV: RR 132/73 HR 119 MAP 105 Hgb 9.0 Plt 306
	Abd: soft, supple, NT, ND hypoactive BS
	Nutrition: Promote 10 cc/hour (lost Dobhoff in pm, replaced this am) GGT 76
	F/E/N: I 3139 / O 2895 138 / 103 / 14 / 129 SGPT 614
	Ur 1675 CT (R) 400 3.9 / 32 / .8 SGOT 112 Alk phos 91
	NG 850 Bili T/D = 1.0/.4 LDH 554
	ID: Tm 38.1 WBC 27.7↑ (24.4) ØABX
	A/P – Re-start TF once KUB ✓
	– Continue rewarming pt. → OOB
	[signature]
	[signature] #281
12/11/98	Trauma
	Neuro A+O×3
	CTA (B) 2L NC 97%
	CV – 152/93 MAP 105 P 116 Hg 9.0 Plt 306
	Abd – soft, ND, ⊕ BS
	Wound – open / to close delayed 1° closure
	Tmax 38.9 UO 1675
	I / / O NGT 850 CT 400
	A/p – Pt stable overnight c̄ BiPAP
	Will close wound delayed 1° closure
	Transfer to Unit.
	[signature]

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
12/11/98	Gen STAFF
	HD5
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	A/P: [illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]

Date of Service	
Date & Time	Case Mgmt:
12/11	Chart reviewed. Contacted MacGregor in regards to QON status. Will continue to follow. Please page for d/c plan needs. —J. Lipson 3485
12/11/98 1400 3E	Occupational Therapy Consult Pt. is a 24 y/o ♂ SIP mult GSW's to (L) clavicle, (R) abd., (R) chest adm. 12/7/98 + underwent E-lap for hepatorraphy, PTX, hepatic artery repair + cholecystectomy PMHx: ? Soc: Pt. works for Metro (cleaning busses + shelters") Lives @ wife + 2 children. Plans on college. S: "I feel like I may have to vomit." O: Pt. in STIC up in neurochair @ NG tube, pulse oxymeter, IV L forearm, nasal cannula O_2, foley, CT. Cog./Mvt: Pt. alert, ox3 + able to follow all commands. ROM: BUE's WNL's. Strength: BUE's WFL's 4+/5 Tag 4/ earlier 138-149 Endurance - tires easily @ raising arms 2x. Sensation - intact BUE's. ADL's: Deferred until further activity orders A: Pt. is 24 y/o ♂ SIP mult GSW's @ OT Consult cont.

430016 (Back Page)

HERMANN HOSPITAL

Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
	OT Consult
12-11-98	internal injuries currently in STIC
	on mult support & monitors,
	Pt. alert, oriented & able to follow
	instruction. Pt. nauseated &
	@ ↓ endurance, High WBC per
	nursing.
	P: will follow pt. 2-3X/wk for ↑ ADL activity
	+ endurance conditioning as condition
	permits. Goals initially to 1.) ↑
	upright endurance to tolerate activity
	for 30+ min, 2.) pt. to participate
	in UE cond. ex's 10-20 min, 3.) Pt. to
	participate in full ADL assessment.
	4.) Pt./family to demonstrate understanding
	i.e.: Rx + DC plan to higher level of care.
	[signature], OTR, CHT

Date of Service

Date & Time	12/11/98 @ 1720

#6

Your patient has been evaluated by the Respiratory Therapy Consult Service. Based on the clinical indicators derived from the following assessment, the Care plan designated below will be implemented

Breath Sounds	Breathing Pattern	Cough	Sputum Production	Mobility
☑ clear	☑ nonlabored	☐ strong	☑ none	☐ ambulatory
☐ diminished	☐ labored	☑ fair	☐ sm. amt.	☑ up w/ assist
☐ fine	☐ shallow	☐ weak	☐ mod. amt.	☐ bed rest
☐ coarse	☐ irregular	☐ absent	☐ lg. amt.	☐ paraplegia
☐ wheezes	☐ rapid		Consistancy/Color	☐ quadriplegic
☐ absent	☐ mech. vent.		☐ thin	
☐ stridor			☐ mod.	
			☐ thick	

Mental Status	Chest X-ray	Vital Signs	Lab	Lung Volumes
☑ alert	☐ clear	HR 121	WBC 27.7	Actual: PF ___ IC 800mls VC ___
☐ obtunded	☐ infiltrates	RR 16	Hg 9.0	Predicted: PF ___ IC ___ VC ___
☐ confused	☐ atelectasis	BP 149/53	SpO2 96% 3l NC	
☐ unresponsive	☑ pleur. effus.	Temp 98.4		
	☐ pulm. cont.			
	☐ rib fx			
	☐ not avail.			

431485

RESPIRATORY CARE PLAN

Medicated Aerosol Therapy NEB MDI IPPB Frequency ______

Aerosolized Medication: ______

Volume Expansion Therapy IS (IDB) Frequency Q4°

Bronchial Hygiene Therapy PD Perc IPV Frequency ______

Spinal Cord Protocol: ______ Frequency ______

Oxygen Therapy FIO2 LPM Delivery Device ______

Comments Pt ~~refuses~~ ~~Error~~ NSS is unable to take deep breaths due to incision. IDB's needed HTC WBC's 27.7 ē Head RN

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	
12/12/98 6 50	TRAUMA Tm 98.4 BP 164/108 P120 I/O 4479/1608 PE: Lungs: Clear, labored breathing, O2 Sat 95% on 15L NRB, CT 410, small air leak. Abd: Incision packed, healing, +BS, NT CV: S1S2, 0m Ext: FROM, ⊘gross m/s deficits. Imp: Mild Resp distress. Plan: Lasix Ambulate, Cont breathing Tx.

TRAUMA/GENERAL SURGERY ATTENDING NOTE 12/14/98
Date 12/12 Patient Walters
Pt seen, examined & discussed with Dr. Floyd
S I P E L A P

System	Comment	Plan
Neuro	A&Ox4, FC CT=410	H2O seal
Pulmonary	Stable SPO2=94% RR=40	
C.V.	164/108, P=120	LFT's
ABD	Distended	quite high
	Nontender	CT Abdomen
I/O	4479/1608	
TM	=98.4 WBC=20,000	

Frederick A. Moore, M.D.

Date of Service

Date & Time	
12-12-98	transport note - nurse
1415	transported pt to & from CT for scan of chest & abd. pt was given contrast oral in scan. Had 2 episodes of emesis & also very agitated given 2mg MSO4 to help keep pt calm. He kept taking off the nonrebreather mask. CT scan was completed no incident on return trip. [illegible]
12-12-98	NURSING SUMMARY ē 10A-7P
1630	RECEIVED PT. @ 1000 TO STICU #19 ē REPORTED RESP. DISTRESS, PRESENTED ē 150/82, 133, 36.7 & RR 24, SpO2 98% [NEURO] AAO, FC, GCS 15, PERRL & 3+, MSO4 & ATIVAN GIVEN FOR PAIN & SEDATION [RESP] RR = 24-42, SpO2 93-100%, PRODUCTIVE COUGH, LABORED BREATHING MOST OF SHIFT, DR.'S TALEBI & SUMNER AWARE, ⓡ PLEURAL CT TO WS [CV] ⓛ WRIST PIV ē D5½NS ē 20 KCL INFUSING @ 125, MAP 75-131 [GI] SMEAR BM ON ARRIVAL, CLEAR LIQUID DIET ORDERED [GU] UO ADEQUATE [INTEG] ALL DSG'S D/I, ABD ē BEEFY RED WOUND ē NO S/S OF INFECTION, WENT TO CT OF CHEST & ABD. TODAY, RESULTS PENDING, NO INTUBATION @ THIS TIME. ~~~ RENEE' JARVIS, RN

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
	STICU Admit Note
12/12/98	24 y/o B♂ s/p GSW to abdomen → cholecystectomy
	+ ligation of proper hepatic a. Transferred
	back to STICU today 2° worsening Resp.
	distress ~~~ rate of ~40 + St 94%. abdominal
	CT A/P ... results ⓟ RR continues @ 36-40
	c/o Ⓡ UQ pain
	PMHx: ∅ PSHx: ∅ Meds: See MAR NKDA
	PE: T 37.6 BP 165/95 P 131 RR 38 SaO2 99%
	Gen: WDWN B♂ in moderate distress from Ⓡ uq pain
	HEENT: PERRL EOMI o/p ~ lesions
	Neck: supple
	Pulm:
12/13/98	- Called to see and evaluate patient with progressive
1615	respiratory difficulties/distress
Cross Staff:	R/R 52 - on 100% O2 - Sat ~~ 93% -
Dr Gottschalk	7.37/51/70/29. - CXray - increasing markings
	especially on R ~ pneumothorax - ? ARDS - ? Pneumonia
	Recently ate - not been NPO for today -
	Will need TPPV ~ RSI, cricoid pressure and ETT
12/13/98	Anesthesia Staff: Dr GOTTSCHALK.
	For intubation - while still awake - supported
	ventilation then with cricoid pressure -
	Fentanyl 250 µg
	Propofol 200 mg
	+ Succinylcholine 120 mg } the RSI 8.0 tube

Date & Time	Date of Service
	cont:
	circumoral lips - Good AE Bilat auscultation
	stopped regurgitation after tube placed and
	cuff inflated - No clinical evidence of
	aspiration - No fluid seen when tube originally
	placed thru cords!
	Then placed (R) sided NGT - Drained ± 1000 ml
	gastric contents. [signature]
12/13/98	NURSING SUMMARY
7p-7a	Pt A/OX3, PERRL, MAE, anxious, on 100% NRB
	laboring / tachypneic → RR 40's, tiring SATS 93-95%,
	ABG → 7.37/51/70/93% Dr Samner assessing pt
	intubated (a) approx 0130 by anesthesiology, Ø complications
	NGT placed ẽ gastric contents of approx 1200cc dk brn
	drain returned pt had been taking ↑ PO fluids since
	this am, ST 120-130 ẽ ectopy (R) Rad A/L placed by
	Dr Samner, (L) SC TLCL also placed, ABP 150-140/70's
	pulses intact, obese open abd wound → W→D drsg, Bld
	(+) granulation noted, mild nausea relieved ẽ Phenergan IV
	(+) BS Ø BM foley ẽ (+) U/O afebrile, (+) pleural CT
	to H_2O seal ẽ approx 500 cc serous drng, girlfriend
	in to visit upset re: situation, made aware of need
	to intubate pt, ABG labs pending
	Jean Samnick RN

HERMANN HOSPITAL

Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	Trauma HD #7
12-13-98	Pt intubated last night for respiratory distress
	A+O x3 follow commands
	Pulm SIMV 14/26 /900 / 100%/5/15 ⇒ 7.44/43/159/29/6
	CV - P 153 MAP 100 Hg 9.1 Plt 453 CVP 16
	Abd - distended, soft.
	Wound - granulating well K 5.2
	I/O = 3.4/3.9 CT 480 NGT Tmax 37.6 (31)
	φ Abx
	A/p. pt intubated, sedated + paralyzed
	✓ all cultures
	✓ Mg, Ca, Phos, LFT's
	CT ē Necrotic area in liver
	✓ CXR
	[signature]

HERMANN HOSPITAL
PARTMENT OF RADIOLOGY
TEXAS MEDICAL CENTER
6411 FANNIN
HOUSTON, TX 77030-1501
(713) 797-2800
(713) 793-5344 (FAX)

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PROFESSIONAL SERVICES PROVIDED BY:
DEPARTMENT OF RADIOLOGY
THE UNIVERSITY OF TEXAS
MEDICAL SCHOOL AT HOUSTON
6431 FANNIN, SUITE 2.132
HOUSTON, TX 77030
(713) 792-5235

PT NAME: WILFORD ,KANE **
DOB: 05/14/1974 AGE: 24 SEX: M
MR#: 96925490 9367 STATUS: IA

ORD'D BY: DUKE, JAMES H. (TRAUMA)
DT PERF: 12/10/98 AT 05:00 HRS.
REQUISITION NO: 01232089
MED RECORDS (CHART) COPY

N/S: ORTR RM/BD: J553 OR VISIT CLINIC:
INDICATIONS: OPN WOUND SITE NOS-COMP

EXAM(S) PERFORMED: ABDOMEN SINGLE VIEW

PORTABLE ABDOMEN, 12-10-98:
INDICATION: Open wound.
****
IMPRESSION:
1. Recommend repositioning feeding tube more distally in proximal GI tract if possible.
2. Loops of large and small bowel are still distended. This possibly represents ileus.
****
FINDINGS: Note that the film was obtained on 12-10-98, but just now returned for interpretation. The feeding tube tip is now located near the gastric body, and the nasogastric tube tip is located in the left upper quadrant of the gastric fundus. The distended loops of large and small bowel are essentially unchanged.

READ RADIOLOGIST:
ATTN MD: DUKE, JAMES H. (TRAUMA) RESIDENT:
APPROV RAD: RESULTS REC'D: 98/12/30 09:27
RESULTS APPROVED: 12/10/98 05:00 RESULTS READ :

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
	STICU HD # 7 ICU D R
12/13/98	Neuro: A/A, FC / MAE
	Pulm: SIMV / 12 / 28 / 900 / 80% / 5 / 15 Scomp 21
	7.40 / 47 / 336 / 29 / 5 / 98%
	Coarse BS (B) R > L
	CV: P 135 MAP 97 CVP 16
	Hgb 9' Plts 453
	RRR, tachy
Sucralfate	FEN: I/O 3.4/3.9 Uo 1.9 Emesis 200
TEDs/SCDs	137 / 103 / 16 / 201; 5.2 / 30 / 6.9 NG 1.3
	CT (R) 480
	Abd softly distended (B) BS ✓ NT - voluntary guarding
	ID: Tm 37^6 WBC's 31°
	∅ abx
	A/P: Resp failure - wean FiO2
	CV - HD stable
	Hyperkalemia - ✓
	CT - cont drainage
	Hyperglycemia / ↑ WBC's → ? digested pressure
	Inpatient ↑ septic picture
	CT prophylaxis
	[illegible signature] MD

Date & Time	Physical Therapy
12/13/98	Consult received + chart reviewed. Deferred
10:35	evaluation @ this time 2° PMD BP.
	Will ✓ later if time permits. —RVizza, PT

Date of Service

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
12/13/98	See STAFF
	HD 7
	[illegible] yesterday 2° resp distress.. CT [illegible] → large hepatic infarct
	loculated pl. effusion Ⓡ.
	neuro - awake [illegible]
	pulm - SIMV [illegible] / 500 / 100 / 5 / 15 → sats 100%
	Secretions [illegible] SC 21 7.44 / 43 / 59 / 25 / 6 / 90%
	Hr 157 MAP 100 Hgb 9.1 PLT 473 CVP 16
	ABD - soft · distended [illegible] [illegible]
	Ext - no [illegible]
	3.4 / 3.9 ALP 119 AST 113 [illegible] 480 [illegible]
	Na 132 [illegible] Cr 0.5 [illegible] 201 Mg 2.0
	Tm 37.6 [illegible] 31.° : [illegible]
	(A/P) ↓ LFTs
	Δ vent to [illegible] [illegible]
	Continue feeding [illegible]
	[illegible] → [illegible]
	[signature]

Date & Time	Date of Service
12/13/98 1415 3Eval (PT/OT)	Physical Therapy Initial Evaluation HPI: Pt. is a 24 YIO BM who was admitted to HH on 12/7/98 S/P GSW to the (L) clavicle, (R) abdomen, (R) chest. Underwent Chest tube placement on (R) 2° hemothorax and exp-lap & ligation of common hepatic artery, cholecystectomy & lower liver hemorrhage controlled & pringle maneuver on day of admit. Self-extubated on 12/10/98. Transferred to SIMU on 12/11/98, returned to STICU on 12/12 2° respiratory distress. Pt. re-intubated on 12/12/98. PMH: ? PSH: ? Referral: 12/10/98 12/13/98 Reconsult PT Dr. Hurtado Precautions: Standard Activity level: bedrest S> Pt. writing notes; gesturing that he's hot and needs oxygen. Requested for a wash cloth, wanted to remove gown. Home situation: Pt. lives in a one story house & grandmother. (F) PTA Works for Metro buses— cleans buses O> Pt. seen at BIS lying supine, (+) endotracheal tube, (+) NGT, (+) CT (R) side, (+) dressing on abdomen, (+) (B) wrist restraints, (+) foley catheter, (+) TED hose / SCD's (B) LE, (+) central line, (+) art line (R) radial artery, (+) pulsox (R) hand, (+) BP cuff (L) upper arm. Pt. is obese. HR: 150-155 bpm BP: 130's-140's/70's-9 mmHg > Mental Status: oriented to his name, stays awake and follows commands. Communicates by gesturing and writing notes or & spelling board / communication board oriented X3 > ROM: (B) UE AROM WFLs (B) LE AROM WFLs > Strength: attempted to apply resistance maneuver, BP would ↑, SD defined applying resistance. Pt. appeared to have at least 3+-4/5 mm strength (B) UE/LE Amna Qureshi, PT

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	(cont Pt Note)
12/13/98	→ Sensation: intact to LT throughout (B) UE/LE
	→ Bed Mobility: pt. able to scoot and turn (E ~~mat~~ cinch) w/in available space and as allowed by lines & tubes ↑ mod (A)
	→ Transfers } deferred
	→ Ambulation }
	→ Rx: Consult received, chart reviewed, eval & Rx initiated. Performed (B) LE AROM ex x 15 Reps. Spoke to pt's step-mom & dad when they arrived p Rx session about home situation & pt's prior level of function. Left pt. ↑ all rails up.
	A→ Pt. is a 24 y/o BM who was readmitted to HH+ on 12/7/98 s/p GSW to (R) chest, (L) clavicle, and (R) abdomen. Underwent (R) CT placement and exploration & ligation of common hepatic a., cholecystectomy & controlling of liver hemorrhage. Re-intubated on 12/13/98 secondary to respiratory distress. At this time, pt. is on bedrest. Pt. is cognitively intact and appears to have functional strength (B) UE/LE, although BP ↑ ↑ application of resistance to assess min. strength. Deferred transfers & ambulation until medically stable. Currently needs (A) ↑ bed mobility. Anticipate need of (A) ↑ transfers & ambulation, initially but may progress favorably
	Goals: 1) Preserve ROM & strength (B) LE
	2) Pt/ family will be (I) ↑ HEP
	3) Prevent 2° complications of prolonged bedrest
	Recommend: 1) turn q 2°
	2) OOB to chair when cleared by 1° team →
	P→ Pt. will be seen 5-7x/week for TherEx, Assess transfers & ambulation when appropriate, pt/ family education, (A) ↑ D/C planning & equipment recommendation. [illegible] PT #2220

Date of Service

Date & Time	NURSING SUMMARY ē 7A-7P
12-13-98	[NEURO] SLEPT MOST OF SHIFT D/T SEDATION GIVEN IN THE AM:
1600	TOTALS: MSO4 24 mg, ATIVAN 6 mg, ROCURONIUM 50 mg. NO
	OTHER Δ'S [RESP] VENT: IMV 15, V_T 700, FiO_2 50%, PS 15, P5
	ē SpO_2 98-100%, CT REMAINS TO DRAIN DARK RED BLOOD
	130cc [CV] ~1030 PT. BECAME HYPERTENSIVE, TACHYCARDIC,
	TACHYPNEIC OF 240/95, 190, 36-42 ē SpO_2 92% & WAS
	SHIVERING C/O "COLD", T = 40 UNRELIEVED BY 0800 DOSE OF
	TYLENOL, ALL SEDATION, PARALYTIC, ESMOLOL & IBUPROFEN
	GIVEN, (L) WRIST PIV D/C'D, PAN CX & LFT'S SENT,
	12 LEAD EKG DONE [GI] NGT ē 1100 OUT, VOMITING EMESIS
	IN NGT & POSS. GASTRIC ASPIRATION (BROWN SUBSTANCE SUCTIONED
	DURING HYPERTENSIVE EVENT, RELIEVED BY PHENERGAN,
	∅ BM [GU] UO ↓ IN AM, REPLACED FOLEY D/T POSSIBLE
	DISPLACEMENT, BRIGHT RED BLOOD NOTED FROM
	PENILE OPENING, UO MARGINAL NOW (SEE FLOWSHEET)
	[INTEG] ∅ Δ [PSYCH] FAMILY @ BS & UPDATED ABOUT
	PT'S STATUS ~~~~ RENEE' JARVIS, RN
12/14/98	Nursing summary —
7p-7a	[NEURO] A/FC MAE, intermittently agitated, medicated ē MSO4 +
	Ativan PRN ē (+) results [PULM] SIMV 15/.50/700/PS 10 P5
	mild bibasilar crackles, SATS >97%, RR 20's, [CV] ST
	120-130's, ectopy, BP stable, CVP 10-14, MAP 80's,
	pulses intact [GI] NPO ∅ N/V, NGT ē 800cc dk brown drng,
	(R) chest CT ē 75cc serosang drng, obese ↓ BS, med amt
	loose stools this shift [GU] foley ē (+) U/O hematuria
	clearing, tmax 38.7 cultured (12/12), [illegible] → [illegible]
	[illegible] ē S/S infection noted, family updated during visits &

via phone calls, AM labs pending — [illegible signature]

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
12/14/98	STICU HD # 8
0800	Neuro: A/A/O, FC, MAE
	Pulm: CTA (B) SIMV 13/25/ Vt 700 / 30% / PS 15 Peep 5
	S_pO_2 98% 7.49/37/79/28/6/96%
	CV: BP 130/79 HR 132 MAP 81 CVP 10 Hgb 7.7 Plt 459
	Abd: soft, nontender, midline incision packed granulating
	Nutrition: NPO
	F/E/N: I 4330 / O 4390 BM 144 | 107 | 21 / 118
	2285 UO 4.2 | 31 | 0.9
	1900 NGT
	205 (R) CT (SGPT) ALT 151 Alk phos 67 T/D 1.9/1.
	(SGOT) AST 157 LDH 575 Mg 2.0
	ID: Tm 40 WBC 15.3 (31.0) Abx Ø
	A/P - ↓ Hgb 7.7 (9.1), 2 U PRBC
	CT, cont. drainage
	↑ BM, send for C. difficile toxin, fecal leukocytes
	[signature]
	[signature]

TRAUMA/CRITICAL CARE ATTENDING NOTE - Date 12/14 Patient Wilford
Patient seen, examined, and discussed with: ✓ Trauma Team, ✓ ICU Team
Specifically reviewed plan with Dr. Tatedo
HD#8 GSW ABD - Hepatic Artery ligation

System	Resp Fcommodure	Plan
Neuro: A + A, FC	Cst = 35	CT chest ABD & Chest No abscesses
Pulmonary: IMV = 15 (25)	Vt = 700 PS = 15 (410) PEEP = 5 VE = 16-17 L/M	7.49/37/79
Cardiovascular MAP = 81	P = 125 Hb = 7.7 →	2 Units PRBC's
CVP = 14	CT = 205	✓ H/H
Abdomen: Distended	⊕ BS ↗ Stress Gastritis: N.I.	No leak Gastrografin ✓ N J Tube
I/O: Weight 4300/4400	NG = 1900cc Wt lyte DVT Prophylaxis: N.I.	SCD'S Today
ID T_m = 39.9 WBC = 15,100	Antibiotics (N.I.)	

Frederick A. Moore, M.D. [signature]

Date & Time	STICU HD 8
12/14/98	Neuro: A/4 / FC / MAE
	Pulm: SIMV / 15/25 / 700 / 15 / 5 / 30% Mod Thick TAN
	7.49 / 37 / 79 / 28 / 6 / 96%
	Coarse (B) BS Sleep ≅ 35
	CV: P 125 MAP 81
	Hgb 7.7 CVP 14
	RRR
Sunalfate	FEN: I/o 4.3/4.4 Uo 2.3 BM x III
30's /SCD's	144 / 107 / 21 / 118 ; 4.2 / 31 / .9 Alb 1900
	CT 205
	Abd distended ⊝ BS NT
	ID: Tm 39.9 WBC's 15.1
	∅ abx
	A/P: 4 LFT's + resp failure
	Support & Live on CT
	Anemia → 2u PRBC's
	NJ for nutrition
	[illegible], MD

Date of Service

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
	PHYSICAL THERAPY NOTE
12/14/98	S: Ø. Pt awake & alert, communicating c̄ eyes, nodding &
9.45	hands. Pt in no apparent distress.
R 2	O: Pt performed (B) LE AROM x 15 reps avail planes in
	supine c̄ appropriate resting breaks. (B) UE exs deferred
	2° pt receiving blood unit. Gentle stretches were applied to
	(B) calves & HS. Pt remained supine c̄ (B) hands restrained.
	A: Pt tol Rx well. Pt required resting breaks 2° RR
	ranging from 29-37 BPM. SaO2 85-99 % during
	activities.
	P: Cont PT as planned —[illegible], LPTA/R. [illegible] SPT/PT
12/14/98	TRAUMA
10 AM	Neuro → Sedated //
	Pulm - [illegible] 15/25 700 / 15 / 5 / 30% MV 16
	7.49 / 37 / 79 / 28 / 6
	CV → P 125 // MAP 81 // Hct 7.7 //
	Abd [illegible], [illegible] [illegible] //
	[illegible] [illegible] // [illegible]
	UOP 2.3 3 [illegible] NGT 1400 [illegible]
	ø [illegible]
	A/P (1) NJ tube by procedure team
	(2) Blood transfusion
	[signature]
	[illegible]

Date of Service

Date & Time	NURSING NOTE : 7A-7P
12-14-98	NEURO ANXIOUS, FC, MAE, ABLE TO WRITE & COMMUNICATE
1630	THAT HE WAS SCARED OF DYING. TOTAL OF MSO_4 22 mg
	ATIVAN 10 mg GIVEN c GOOD RESULTS RESP ND VENT.
	A's THIS SHIFT, REMAINS ON 15/50/700/15/5, SpO_2
	96-100% & GAS OF 7.49/37/79/28/L, CT TO WS c DK.
	RED BLOOD DRNG. HICCUPS NOTED X 3, THORAZINE
	ORDERED PRN BUT p 3rd TIME & NOT GIVEN YET
	CV AM H/H 7.9, 2U pRBC'S GIVEN c POST-TRANS. H/H OF
	8.9, WILL START SERIAL H/H Q6°. TLC & AL PATENT
	REMAINS TACHY 125-140 GI VOMITED X 1 WHICH WAS
	RELIEVED BY PHENERGAN, NGT IN PLACE, REMAINS NPO
	c FEEDING ACCESS PLANNED FOR THIS WK PER DR. WOOD/R BEVER
	X 24 hr, BM X 11 GU ADEQUATE OUTPUT INTEG ALL WOUNDS
	s S/S OF INFECTION, REMAINS TO BE FEBRILE c
	TM 39.4, IBUPROFEN GIVEN PSYCH FAMILY @ BS FOR SHORT
	PERIODS c ?'s & CONCERNS ADDRESSED. RJARVIS, RN
12-15-98 0540	Nursing Summary 7p-7a: Neuro perrl. tracks follows commands.
	occas agitated >pm MSO_4/Ativan. CV Stable - see flowsheet. Resp
	RR 20's-30. SpO_2 ≥ 92%. GU Mod amt brown NGT output. No
	bm. No A abd wound from assessment. GU QSUOP. Skin Tmax
	38.5 - Ibuprofen given. Family girlfriend called. Labs Tri am
	H/H 8.7/26.9. Jennifer Lynch

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
	STICU HD 9
12/15/98	Neuro: A/A, FC / MAE
	Pulm: SIMV / 15/25 / 700 / 30% / 5/15 Minimal sec.
	ABG 7.46 / 37 / 86 / 26 / 21
	CTA(B) Mechanics R 30 / 33 / 11.9 / 400 / -50 / +
	CV: P 120 MAP 92 CVP 7
	Hgb 8.9 TTR tachy
Sucralfate	FEN: I/O 4.0/3.2 Uo 2.3 BM x 4
TEDs/SCDs	144 / 113 / 17 / 109 ; 4.6 ; 2.2 ; 2.3 NG 550
	4.2 / 23 / 0.8 CT 30 [illegible]
	Abd softly distended ⊕ BS wound ok
	ID: Tm 39.4 WBC's 18.6
	Cefepime / Fluconazole — [illegible] ⊝ in blood 12/13
	R. [illegible] → urine 12/13 >100K
	A/P: wean SIMV to CPAP
	Anemia – stable
	✓ chem – 7
	Cont. abx
	[illegible signature] MD

		Date of Service
Date & Time	Occupational Therapy Note	
12-15-98	S: Pt. alert & cooperative.	
0950	O: Pt seen for [illegible] BUE's 2 sets/10 reps.	
IND	shoulders & hands. Encouraged pt. to	
	do [illegible] program.	
	A: Pt. @ good UE strength & following	
	all commands.	
	P: Cont. Rx. plan.	
	[signature], OTR	

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	
	Trauma HO eg
12/15/98	Neuro - alert, follows commands, intubated
	Pulm - SIMV 15/25/700/30%/5/15 — 7.46/37/86/24/4
	CV - P 117 MAP 92 CVP 7 Hg 8.9 Tachy
	F/o = U.O 2325 NGT 550 Stool 3
	Abd - soft, distended, BS, Wound - open - granulating
	Cultures - gm⊖ rods - blood, Gram - urine Temp 39.4 18.6
	A/P - Pt was empirically started on cefepime / flagyl.
	Need to add gentamycin / D/C flagyl.
	Needs NG tube placement
	Pt c cortical area of necrosis of liver on CT scan c bleed in center. May need angio of this "bleed" in liver & then OR ⇒ for I+D and drainage

TRAUMA/CRITICAL CARE ATTENDING NOTE - Date 12/15 Patient Walker
Patient seen, examined, and discussed with: ✓ Trauma Team, ✓ TCU Team
Specifically reviewed plan with Dr. Summers & Dubose
HD # 9

System	Comment	
Neuro: Unchanged		RR=32 VE=12 Vc=800 Vt=396 Plan W/F −50
Pulmonary: IMV=15(25) Vt=700 FIO2=.3 PEEP=5 PS=15(30) 500		7.46/37/86 VE=15 L/M ↓ Rate
Cardiovascular MAP=92	P=120 CVP=7	⊕ Blood culture gm⊖
	Hb=8.9	VRE - >100,000 E. Coli
Abdomen: Soft Distended ⊕ BS's	Stress Gastritis : NG Suction NO Tube	
	DVT Prophylaxis: SCD's	
ID T_m=39.4 WBC=16,600	Antibiotics : Cefepime / Flagyl / Gentamycin 5-7d / 12/22	

Frederick A. Moore, M.D.

Date & Time	Date of Service

S/TICU PROCEDURE : LINE ~~INSERTION~~ Date 12/15/98 Time 17:45

Line type: PAC (CVP) A-line Jug Bulb

Indications: (Hypotension) Hypertension Oliguria Pacing Fluid infusion Hyperventilation
Heart failure Resp: fail ARDS (PEEP, Hypoxia) Shock:cardio, hypovol, septic
Myocardial ischemia Tachycardia(unexplained) No peripheral site available
Emergent Other:

Prep: (Betadine) Alcohol Other _____ Anesthesia: Lidocaine 1% None Other _____

Side : Right (Left) Site : IJ EJ (SC) Femoral Radial Axillary Dorsalis pedis Jug Bulb Other

Cath Size _____ Technique : (Over-wire) New puncture

X-ray : N/A Pneumothorax Tip position _____

Complications : Ø

Procedure note: Using Seldinger technique line changed. Tip submitted for Cx.

Attending : _____ Resident [illegible]

SA NC CC SK LP AT

12/15/98 515

I&D

Dx: S/P GSW c ~~antibiotic~~ subdiaph abscess

Procedure: Abscess drain

Physician: Alaster, Cohen

Findings: 10 F APD Cath placed in subdiaph abscess. Foul-smelling material sent for culture + gram stain

Ø complication

Dale R Alaster, MD
404-3879

430016 (Back Page)

HERMANN HOSPITAL

Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
12/15/98 1630	Nursing Summary 7A-7P Shift
	Eyes Equal Reactive. Follows Commands. Pt continues to reach to ETT when hands released. Restraints applied. Releases when
	Rom Provided. O2 sats 94-95% on Vent. Simv 12 TV 700 FiO2 PEEP 5 30% O2. Chest tube to R. Chest with dark red/
	brown drainage. Chest tube DSG changed. Odor to site. Pt sinus tachycardic. 120's. H+H Q6 (Similar results).
	BP mild hypertension. Given MSO4 for sedation, Pt stated he was comfortable on occassion. Pt denied pain when
	asked later in day. Given Sedation prior to Central line being wired out. Pt has bowel sounds small stool drained
	in early am. Abdomen distended soft. Urine output exceeds 60 cc's per hour. Pt has wound to left shoulder
	Wound to RLQ. Abdomen incision. exit wound to back. Wounds granulating. Pts mother and relative to bedside.
	UA., Blood C+S, and Urine C+S sent to lab. Tip Culture sent to lab. Pt to Interventional radiology
	for drainage of fluid to Hepatic area. Abd dsg D'd. — [illegible] RN
12/16/98 0420	Nursing Summary 7P-7A: ① Neuro: No Δ's, MAE, PERRL.
	② HD: BP stable. CV: Continues ST ō ectopy
	in 110's at this time. ③ Infection: Febrile c̄
	ibuprofen given c̄ ↓T to 38.0°C. Cultures done
	on previous shift. ④ FEN: Continues on NS @ 125cc/hr
	NPO. u/o > 30cc/°. AM Labs pending. ⑤ Skin: No skin
	breakdown. abd. wound c̄ W→D Drsg adipose tissue
	clean no SXS infection. ⑥ Family: Family to
	bedside c̄ questions & concerns addressed. Vital
	signs reviewed. — G. Scott RN

Date of Service

Date & Time	
	STICU HD 10
12/16/98	Neuro: A/A, FC, MAE
	Pulm: SIMV / 12/21 / 700 / 5 / 15 / 20% BS 500's
	ABG 7.47 / 32 / 69 / 24 / 1 / 95%
	CV: P 105 MAP 91 CVP –
	Hgb 8[4] Plts 426 RR, steady
	FEN: I/O 3.2 / 3.8 UO 2.9 BM x 4
	147 / 4.4 | 115 / 21 | 13 / 0.8 < 110, 4.32, 29 NG ∅
	Hepatic drain 640
	CT 250 ∅ leak
	ID: Tmax 39° WBC's 17[4] (18[6])
	Cefepime
	A/P: ✓ mechanics
	HD stable
	Replete Mg
	Cont. abx + drainage
	[signature] MD

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date & Time	Date of Service
12/16/98 0745	IR Temp 38° WBC 17.4 Subdiaphragmatic tube - 640cc brown cloudy material. Skin site dry & clean. Will continue to follow & assess drainage. Cult: Cx pending - Wiez [illegible] [signature] Dale R [illegible], MD 404-3679
12/16/98 10 AM	TRAUMA IR placed drain yesterday. || POD #10 AA FC MAE SBMV 12 | 21 700 5/15 30% (500) 7.47/32/69/24 | - Pulses MAP 81 || Hgb 8.4 - [illegible] drain in place || Midline wound open || Tbili 3.2/3.8 UOP 29 BMx4 (Gt 250) Tm 39.0 WBC 17.4 Abx [illegible] - √ Chest Tube for bile - √ [illegible] of Abd drain. - PEJ [illegible] [signature]

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THE UNIVERSITY OF TEXAS
MEDICAL SCHOOL AT HOUSTON
6431 FANNIN, SUITE 2.132
HOUSTON, TX 77030
(713) 792-5235

PT NAME: WILFORD ,KANE **
DOB: 05/14/1974 AGE: 24 SEX: M
MR#: 96925490 9367 STATUS: IA

ORD'D BY: DUKE, JAMES H. (TRAUMA)
DT PERF: 12/12/98 AT 13:25 HRS.
REQUISITION NO: 01233589
MED RECORDS (CHART) COPY

N/S: STIC RM/BD: STIC19 OR VISIT CLINIC:
INDICATIONS: OPN WOUND SITE NOS-COMP

EXAM(S) PERFORMED: CT CHEST W/O CM

THORACIC CT, 12/12/98:
REASON FOR STUDY: Open wound and possible fluid.
****
IMPRESSION:
1. Bibasilar atelectasis versus pneumonia, right greater than left.
2. Loculated right hydropneumothorax.
3. Large liver laceration/hematoma or infarction. Recommend correlation with the recent body CT. There is also suggestion of large subcapsular hematoma and a small amount of fluid in the hepatorenal space.
****
TECHNIQUE: 7 mm thick transaxial unenhanced helical CT images were obtained from the lung apices down through the diaphragm.
FINDINGS: A right hydropneumothorax is present. Linear densities seen within the air component of the hydropneumothorax are compatible with loculations. A right thoracotomy tube has been placed with its tip located posteriorly within the fluid component of the hydropneumothorax. A bullet fragment occupies the left lung apex, and this results in artifact. Right lower lobe density containing air bronchograms is compatible with atelectasis versus pneumonia. Similar but less pronounced findings are seen in the left lung base. A large, irregular, hypodense defect is noted throughout the right hepatic lobe, compatible with hematoma versus infarction. Recommend correlation with the recent body CT. Hypodense region seen superiorly and laterally about the right hepatic lobe has the appearance of a subcapsular hematoma. Hypodensity in the hepatorenal pouch is consistent with a small amount of free intraperitoneal fluid.

READ RADIOLOGIST:
ATTN MD: DUKE, JAMES H. (TRAUMA) RESIDENT:
APPROV RAD: RESULTS REC'D: 98/12/15 09:23
RESULTS APPROVED: 12/12/98 13:25 RESULTS READ :

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	TRAUMA HD 14
12/18/98	
	Neuro FC 11 MAS
	CV P 116 BP 151/83 CT output 167 (188.4)
	Pulm SIMV TV 700 / 5/15 MV 16
	Abd soft BS ↓(500-600)
	[illegible] wound ‖ I/O 3.1 / 4.4 Pressure 45cc/h
	[illegible] →
	Amp → (sensitive) Cef/Gent → (Ecoli)
	WBC 16.5 (23.8) DVT [illegible]
	↓PS to 10
	- [struck out] - Adm TFs (20 / 110)
	- Avoid GI consult
	[signature]

TRAUMA/CRITICAL CARE ATTENDING NOTE - Date 12/ Patient Wilford
Patient seen, examined, and discussed with: ✓ Trauma Team, ✓ ICU Team
Specifically reviewed plan with Dr. Bengers
HD# 14

System	Comment	Plan
Neuro: A&A	FC, PS=15 (600)	
Pulmonary: IMV=	4 (26) Vt=700 PEEP=5 FIO2	5 VE=16 > ↓PS=10
Cardiovascular MAP=104	P= 105	CT= 167
Hb=84	Pressure 45cc	IR - Placed Drain (R) diaphragm 35cc
Abdomen: Soft Wound	(+) BS	Stress Gastritis: ~~N.~~ I. Improving
I/O: 3900/4000	DVT Prophylaxis: ~~N.~~	SCD
ID Tm=38.5 WBC=16	90? Antibiotics: ~~N.~~	Amp/ Cef/ Gent ⇒ Intra-abdominal abscess 3rd [illegible]

Frederick A. Moore, M.D.

Date & Time	Date of Service
	Pulmonary Diagnostic Lab - Metabolic Gas Analy[sis]
12/18/98	RQ = .78 REE = 3734. Thank you D Sheila Camillo[?]
12P	
I.M.NT	Nutrition Note
12-18	O Promote
	REE 3734 ± 221 RQ .78
	A Est Needs (REE x .75) 2800 kcal, 170 gm Pro
	to promote ⊕ N balance while
	maintaining copious energy reserves.
	P IMPACT FS 115cc q h Goal.
	Discussed plan of care c̄ multidisci-
	plinary team on rounds.
	Jo[?] Duggan RD
	22117
12/18/98	JR
2:20P	WBC ↓
	SUB DIA DRAIN c̄ ONLY 25cc RECORDED
	MAY NEED TO RE-CT ABD IF FOLGER[?] DOES
	NOT ↓↓. [signature] MD
	60257701

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

Kane Wilford

Date of Service

Date & Time	
12/18/98 4:50 pm	GI fellow Re: placement of a biliary stent for a choledochopleural fistula. HPI: 24 y/o BM admitted on 12/7/98 c multiple GSW, hypotension, hemopneumothorax in (R) chest s/p CT drainage in the OR, he underwent an expl. laparotomy, hepatic artery ligation for hemorrhage, cholecystectomy. He was found to have a liver laceration c the bullet wound noted @ the ant-post surface of the liver. Post-op course was complicated by a sub-diaphragmatic abscess which was drained by IR on 12/15/98. The fluid drainage from this area appears to be bilious. He has E.coli bacteremia/and UTI. The sub-diaph fluids grow GPC/GNR. 12/16 Hepatic drainage total bili ~ 26.3 12/16 ~~Sub-dx~~ chest fluid total bili ~ 8.9 12/14 Serum bili ~ 1.9 Based on the finding of bile in the chest fluid it's suspected that pt has a pleuro-biliary fistula. Pt is on the vent. opens eyes, nods appropriately to commands. PMSH: as above S/H, F/H, All, ROS: unknown Meds: IV Cefepime, ampicillin, Gentamycin IV Pepcid, IVF, TPN O/E: T_m = 39² BP: 130/72 R= On vent CPAP P=110

Date & Time	Date of Service
	Heent: ⊖ icterus. NGT c̄ bilious drainage
	Chest - Bil. harsh BS. Subdiaphragmatic tube c̄ bilious drainage
	Heart: tachy $S_1 S_2^+$ $0S_3 0S_4$. CT → serosang. drainage
	Abd: soft surgical site drained. ↓ BS
	Ext: + edema
	Labs: 16.9 > 8.4 / 25.4 < 556. ~~Tbili:~~
	Imp: ① Possible biliary-pleural fistula 2° trauma
	② Subdiaphragmatic abscess s/p drainage thats bilious
	③ Hepatic abscess 2° Hep. art ligation
	④ Vent. dependence
	Rec: ① HIDA scan to demonstrate bile leak.
	②. Repeat chest fluid and serum bilirubin simultaneously, Existing lab reports are confusing.
	③. If pleural-biliary fistula noted on HIDA scan, there is a Role for ERCP and stent placement to allow bile flow along the path of least resistance. This would allow the fistula to heal
	~~④. ↓ing amounts of subdiaphragmatic drainage is encouraging~~
	O/w agree. [signature] 6/17/07

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Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
18 Dec 1640	GI Staff
	Pt. seen for possible biliary - pleural
	fistula. We have seen + examined
	him + reviewed CT scans etc. He
	has subdiaphragmatic drain that is
	decreasing output; this is bile-stained.
	The chest tube fluid is serosanguinous -
	not obviously bile stained; lab
	reports do not clearly show [bili] in
	this fluid, but are confusing. If
	fistula indeed is present, stenting
	the Ampulla of Vater should favor
	closure. I doubt HIDA scan can
	be done if serum bili is very high -
	hasn't been checked since 12/14 -
	Rec. —
	① Simultaneous serum and
	CT fluid bilirubin
	② Do HIDA scan to look for
	leak - Scan can ... here
	so this may work.
	ERCP / Stent dependent on above
	[signature]
	417-9747

Date of Service

Date & Time	
12/19/98	nsg summary 7p-7A con't c 30% FiO2 placed on IMV 4 for pm rest sm amt cloudy pale sputum VSS temp ↑ → ibuprofen given; UO good liq BM x1 lg amt NO drng L Marin
12/19/98	STICU LID 15
	Neuro: N/A, FC, MAE
	Pulm: CPAP 35% / 5 / 15 PSV 630's V 15
	ABG 7.44/36/86/24/2/95% Sm wh TR
	Mechanics R 29/620/18/1000/-60/+
	CV: P 110 MAP 84 CVP -
	Hgb 8.3
	FEN: I/O 5.3/7.3 UO 5.0 BM x I
	136 / 106 / 10 < 12 ... (4.12, 2, 2, 26) NG 1.2
	4.1 / 22 / 0.7 CT 90
	Dr 10
	ID: Tm 39.3 WBC's 14.7 (16.9)
	Vanc / Fort / Levoquin
	A/P: Resp failure - extubate
	Anemia - ~~transfuse~~
	Sepsis - cont. abx
	[signature]

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	
	Stress St #16 HD# 15 POD 14
12/19	Neuro Awake GCS 11T
	Chest CPAP/PS RR 30's 7.44/36/80 markers
	W/ tachy 102 MAP 87-100 Hgb 8.3 good
	ABD: Soft. ND wnd clean Active BS BMXT
	FEN: 5.3/7.3 NGT 1.2 CT 90cc Prune C60cc/°
	ID TMax 39.3 WBC↓ UA/C/ Levaquin/gat. enterococcus.
	P/w evaluate P HIDA scan
	Plan toilet.
	? need for Levaquin.
12/19/98	Critical Care Transport Team
1030-1430	Transported to nuclear medicine for HIDA scan accd by RN/RT/HCT On EKG/BP/SpO2 monitor C all alarms on. Manual vent C 100% ambu bag for transport → On 7200 while on test C 30/0/V_T 700/RR 4/PS/PS 10 C SpO2 = 100% RR = 22-26 Vitals stable. Plan = 400cc NS during test. Pt tolerated procedure well. Returned to STICU #19 5 problems. Thank you —— Amy Brown

Date & Time	Date of Service
	Stree s/p HD #16
12/20/98	neuro GCS 10
	resp: extubated CXR (B) infiltrate 2L NCO2 sats > 96%
	CV stable Hgb 8.9 stable
	HR 115
	ABD stable, healing fluid TF BM x 8
	FEN good urine output 3.4 L Promote
	NG↑ 900cc ↓ 80cc ↓
	ID Tmax 38[7] WBC 17 (↑14) Vanc / levoflox / gent.
	empiric.
	Plan: Start PO diet, slowly.
	✓cultures, D/c ABX (vanco)
	Send stool C-D16
	Pulm toilet.
	OOB chair
	[signature]

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date & Time	Date of Service
12-19-98	Trauma HO 15 A+O, moves all, F.C CMV 5 / 30% FiO2 Rate 29 / TV 620 / Vm 10.0 / PEEP 5 / @ desired CV - BP 141/90 P 100 MAP 84 Hg 8.3 Abd - soft, ND @ BS, @ BM Wound - granulating - clean/dry IN-O - 5L NET 1.2 L CT 90 cc JP 10 cc Nutrition - Pronutra Temp 39.3 14.7 (16.9) Plan for Resident Extubation / Start Pneumonia A/P - Plan to extubate today Foley remove today 24/7
12-19-98 1830	NSG Summary 7A-7P Neuro @ BS's; CV @ BS's, Rose extubated 5 difficulties @ stridor or Signs of resp. distress; IS upto 1000ml weak cough. FEN finished Bag #3 of Magnesium; ↑ TF to 75ml. x7 BM becoming thicker + semi-formed Orders rec'd for BSC/pt. demand. Tmax 38.6 / Maalox 30mg x2 c good results
12/20/98	NSG Summary 7P-7A # Resp: Resp rate 28-40 NC @ 3L c SaO2 92-99% foul cough / Sputum production # CV: @ pulses # FEN: VO ↑ liq/soft DM ↑ pain: given MSO4 pt restless - 3B unable to get comfortable Maalox

Date & Time	Date of Service
12/20/98	STILL DK
	Neuro: A/A/FC/MAE
	Pulm: NC C 3L 100% SAO2 RR 32
	CTA (B)
	CV: P 115 MAP 83
	Hgb 8.9 BR Tachy
	Renal: Z/o 4.8/7.1 Uo 3.4 BUC 8
	136/4.1 | 103/21 | 10/.7 < 118 4.32 1.9 NG 900 Promote TF's C8
	3.3 CT 80
	(+) BS soft granularity Drain 25
	ID: TM 38.3 WBC's 17 (↓)
	Vanc / Levo / Flagyl
	A/P: Anemia - transfusion
	↑ BM's - ✓ c-diff
	Biliary-pleural fistula - ✓ c GI re stent
	Sepsis/SIRS - cont abx
	[signature]

430016 (Back Page)

HERMANN HOSPITAL

Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date & Time	Date of Service
	Team M HIDA [illegible] biliary leak //
12/12/98 9:00 AM	
	Exh [illegible] //
	CV [illegible] P116 MAP 83 Hg 8.9 (stable)
	Abd soft [illegible] [illegible]
	TFs 90cc/hr
	[illegible] 4.8/7.1 [illegible] 3.4 //
	NGT 900 [illegible] 80cc Drain 25
	BM x8
	Tm 38.3 WBC 17.0 (14.) Vanc/Levo/Cort
	- start PO diet
	- D/C [illegible]
	- f/u Cx's & adjust Abx accordingly
	- f/u C diff toxin.
	[signature]
12/12/98 0855	CCI Attending
	Pt seen & examined. Results of HIDA noted
	above - will set up ERCP & stent placement
	for tomorrow. Indications risks & alternatives
	discussed & patient. [illegible] NPO
	[signature] 617-0703

Date & Time	Date of Service
12/20/98	IR
0920	pt s̄ complaints
	Tmax 38.3 T current 38
	Subdiaph drain - 25cc for 12hrs. 10cc previous 24 hrs.
	Biliary leak per HIDA yesterday - ERCP tomorrow
	Will continue to follow.
	Dale R Absher MD
	404-3679
12/20/98	7A-7P Nsg Summary: See CC flowsheet: neuro-
	pt alert, oriented, PERRLA. CV-ST s̄ ectopy, BP
	stable. Resp- RR 24-32. IS <750. RLQ
	diminished. O2 sats > 96%. GI/GU- No BM;
	U.O. good. Infection- Lab called c̄ ⊕ BC.
	Dr. Zaafran aware. No further O's - [illegible]
12-21-98	Nursing Summary 7P-7A
	GI - Pt c̄ 2 BM's first soft then liquid
	TF off for procedure this AM.
	Resp. Pt's RR in 30's but only
	slightly labored. SaO2's in 96-98%
	[illegible signature]

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date & Time		Date of Service
	Trauma HD #15	
12/21/98	Neuro - alert / FC	
	Pulm - resp 30, clear (B), NC 2-4L	
	CV - P 115 MAP 115 Hg 8.8 Plt 786	
	Abd - soft, NT	
	Wound - healing well, good granulation	
	UO - 4.2L CT 120cc Ø AL	
	KT 5.6	
	Tmax 38.9 19.8 (12.5) Vanc / Diol / Imi - Enterococcus E. coli	
	A/P - Pt c improvement, on 2-4L NC	
	Wound healing, receiving tube feeds	
	Pt c bile leak + extravasation into	
	chest → per bile in CT	
	GI will plan possible ERCP c	
	stenting of bile leak	
	Cont Abx for Enterococcus / E coli, ⊖ wound ⊕ urine ⊕ blood cultures	
	[signature] 24796	

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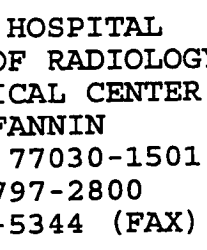

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HOUSTON, TX 77030
(713) 792-5235

PT NAME: WILFORD ,KANE **
DOB: 05/14/1974 AGE: 24 SEX: M
MR#: 96925490 9367 STATUS: IA

ORD'D BY: DUKE, JAMES H. (TRAUMA)
DT PERF: 12/12/98 AT 13:25 HRS.
REQUISITION NO: 01233579
MED RECORDS (CHART) COPY

N/S: STIC RM/BD: STIC19 OR VISIT CLINIC:
INDICATIONS: OPN WOUND SITE NOS-COMP

EXAM(S) PERFORMED: CT ABDOMEN W/CM

HISTORY: Open wound site.
CT SCAN OF THE ABDOMEN:
****
IMPRESSION:
1. Bilateral lower lobe atelectasis and right pleural effusion.
2. Large irregular defect, right lobe of the liver either hematoma or infarct.
3. Ileus.
****
This exam was performed with IV contrast only. Bilateral lower lobe atelectasis is noted, right greater than left. There is a right chest tube as well as small right pleural effusion noted. There is a large irregular defect involving the entire right lobe of the liver with varying degrees of hyperdensities. There is also a large perihepatic fluid collection. These findings are consistent with a hematoma or liver infarct. The kidneys, spleen, pancreas, are otherwise unremarkable. There is diffuse dilatation of both large and small bowel of the abdomen consistent with an ileus. These findings were discussed with the patient's attending resident.

READ RADIOLOGIST:
ATTN MD: DUKE, JAMES H. (TRAUMA) RESIDENT:
APPROV RAD: RESULTS REC'D: 98/12/14 21:27
RESULTS APPROVED: 12/12/98 13:25 RESULTS READ :

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date & Time	Date of Service
	S. ICU
12/21/98	Neuro: A/A, F, MAE
	Pulm: RR 30 SaO2 97% on 3L NC
	CTA (B)
	CV: P 115 MAP 114 CVP –
	Hgb 8.8 Plts 786 RRR
	FEN: I/O 4.2/5.1 Uo 4.2
	135 / 103 / 12 < 101 ; 4.1 / 1.8 / 3.4 NG 750 – cont
	5.6 / 18 / 0.9 CT 120 ø Ik
	Abd soft ⊕ BS Drain ø
	NT/ND [illegible] [illegible]
	ID: Tm 38.9 WBC's 19.8 (17.5)
	Vanco / Gent / [illegible]
	A/P: To [illegible]
	Rev K
	Cont abx
	[signature], MD

Date of Service	
Date & Time	
12/21/98	IA
0720	T max 38.9 Tc 38.1 WBC ↑ 19 (17.5)
	Drain output - ∅ (25cc) (10cc)
	Hida shows intrahepatic lesions.
	Re ✓ CT, then possible drain.
	Medical Arts Dale R Abston, MD
	404-3679

430016 (Back Page)

HERMANN HOSPITAL

Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
	Sticu S/A/G HD#15
12/21/98	neuro GCS 15
	Resp RR 30 intubated on 3L NC O2 97% CTA (B) CXR ↑ (R) hemidi[illegible]
	CV tachy @ 116 MAP 90 Hgb 8.8
	plts 786 ↑
	ABD soft, wound clean, Active BS
	FEN = I/O 4.2/5.1 lytes K+ 5.6 4.2 [illegible]
	TF held for ERCP CO2 18. AG 14
	ID 38.7 max WBC ↑ 19.8 (17.5) Vanc/gent/levo
	E coli / Enterobacter / Enterococcus
	Blood/urine ABD wound.
	Plan: FOR ERCP today.
	watch pulm status.
	may not tolerate procedure, may need intubation prior/post
	procedure.
	Acidosis. [illegible]
	[signature]
12/21/98 CGA	IR Staff
	Have reviewed HIDA scan — leaks bile
	into GSW in liver. Would propose draining bilomas
	and attempting PTC to stent the affected
	ducts. Will f/u Dr. Duke.
	[signature]

Date & Time	Date of Service

S/TICU PROCEDURE : **LINE INSERTION** Date 12/21/98 Time 09:40

Line type: PAC (CVP) A-line Jug Bulb

Indications: Hypotension Hypertension Oliguria Pacing (Fluid infusion) Hyperventilation
Heart failure Resp: fail ARDS (PEEP, Hypoxia) Shock:cardio, hypovol, septic
Myocardial ischemia Tachycardia(unexplained) No peripheral site available
Emergent Other:

Prep: (Betadine) Alcohol Other _____ **Anesthesia:** (Lidocaine 1%) None Other _____

Side : Right (Left) **Site :** IJ ~~Ft~~ ~~SC~~ Femoral Radial Axillary Dorsalis pedis Jug Bulb Other

Cath Size _____ **Technique :** (Over-wire) New puncture

X-ray : N/A Pneumothorax **Tip position** _____

Complications :

Procedure note: Prepped area in usual sterile Condition
Using Seldinger technique line passed.

Attending : _____ Resident [redacted]

SA NC CC SK LP AT

12/21/98	Procedure Note
	Procedure: Ultrasound guided percutaneous
	Drain into Biliary collection within
	liver
	Operators: Abshire, Thompson, Cohen
	Lines: 10 F pigtail catheter in liver
	collection
	Anesthesia: Local lidocaine under
	1 mg Versed & 50 mg Fentanyl.
	Findings: Bloody Bilious fluid under pressure
	Draining freely.
	Comps: None immed.
	Full report to follow
	[redacted]

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	NURSING SUMMARY : 7A-7P
12-21-98	NEURO AAO, FC, MAE, ANXIOUS, MSO_4 & ATIVAN GIVEN. PRN
1400	RESP 3L NC TO KEEP SpO_2 > 92%, RR 32-40. (R) PLEURAL
	CT TO WS CV (L)SC TLC REWIRED, NS ↓ TO TKO, MAP 91-121,
	GI ABD OPEN, BEEFY C GOOD GRANULATION. VASCULAR
	RADIOLOGY FOR INTRAHEPATIC DRAIN INSERTION, SUPRA-
	HEPATIC DRAIN REMAINS IN PLACE, NEW DRAIN C
	BILE DRNG., TF - IMPACT STARTED @ 11D & CLEAR
	LIQUID DIET RESUMED GU ADEQUATE OUTPUT. OTHER
	T_M 38.8, IBUPROFEN GIVEN C GOOD RESULTS. NO
	OTHER Δ'S. RENEE' JARVIS, RN
12/21/98	GI fellow
	Pt. extubated on O_2 per NC
	T_m = 38.9 P-122 BP = 125/72 R-20
	P.E. - unchanged.
	Sub-diaphragmatic drain ø drainage
	Today, Pt. went to IR for US-guided drainage of the intra-
	hepatic biloma c 10F pigtail catheter placement
	Labs: WBC 19.5
	12/20 Bili - from CT fluid 2.4
	serum bili 1.2
	There was no clear cut e/o a second bile leak
	such as a pleuro-biliary fistula. ~~Given the~~ Since the
	pt. appears clinically better and bili levels in CT fluid
	are trending down, will continue to observe. Restart
	tube-feedings.

Date & Time	Date of Service occupational therapy
12/21/98	S: I'll do 50"
1500	O: Pt. issued dumbbell + hand exercises +
INV	discussed UE elbow shoulder exercises @
theraband	care not to strain trunk/abdomen.
hand ex.	A: Pt. tolerated ex's well, + hand weather
	than (R). Pt. agreeable not to overdo
	ex's,
	P: Cont. Rx.
	Brad Burkett, OTR
12/24	Case Management:
	Chart reviewed for continued stay. Please
	page c d/c planning needs. — J. Lyerla
	77435

430016 (Back Page)

HERMANN HOSPITAL

Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	IR Note
12-22-98	
8:30AM	T. 38.6
	Drain output 24 hrs: Intrahepatic 500 —
	suprahepatic Ø
	A/P: cont follow drain output.
	[illegible] 23919
12/22/98	TRAUMA HD#16
9:50AM	N→ A:O MAE FC
	P→ RR 28 98% 2L NC
	CV→ P 125 MAP 106 Hg 9.1
	· Input 125cc/h. Soft | BS
	G 80cc [illegible]
	Intrahepatic Drain ⇒ 500cc //
	Suprahepatic → Ø
	Tm 38.8 || WBC 18.0 (15.8)
	Vanc [illegible] Gent[illegible] Levo[illegible]
	[illegible] / [illegible] / [illegible]
	- OOB to chair
	- √ Drain fluid for [illegible]
	- Continue [illegible]
	[signature]

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(713) 793-5344 (FAX)

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THE UNIVERSITY OF TEXAS
MEDICAL SCHOOL AT HOUSTON
6431 FANNIN, SUITE 2.132
HOUSTON, TX 77030
(713) 792-5235

PT NAME: WILFORD ,KANE **
DOB: 05/14/1974 AGE: 24 SEX: M
MR#: 96925490 9367 STATUS: IA

ORD'D BY: DUKE, JAMES H. (TRAUMA)
DT PERF: 12/12/98 AT 13:25 HRS.
REQUISITION NO: 01233579
MED RECORDS (CHART) COPY

N/S: STIC RM/BD: STIC19 OR VISIT CLINIC:
INDICATIONS: OPN WOUND SITE NOS-COMP

EXAM(S) PERFORMED: CT PELVIS W/ CM

HISTORY: Open wound site.
CT SCAN OF THE ABDOMEN:
****
IMPRESSION:
1. Bilateral lower lobe atelectasis and right pleural effusion.
2. Large irregular defect, right lobe of the liver either hematoma or infarct.
3. Ileus.
****
This exam was performed with IV contrast only. Bilateral lower lobe atelectasis is noted, right greater than left. There is a right chest tube as well as small right pleural effusion noted. There is a large irregular defect involving the entire right lobe of the liver with varying degrees of hyperdensities. There is also a large perihepatic fluid collection. These findings are consistent with a hematoma or liver infarct. The kidneys, spleen, pancreas, are otherwise unremarkable. There is diffuse dilatation of both large and small bowel of the abdomen consistent with an ileus. These findings were discussed with the patient's attending resident.

READ RADIOLOGIST:
ATTN MD: DUKE, JAMES H. (TRAUMA) RESIDENT:
APPROV RAD:
RESULTS APPROVED: 12/12/98 13:25
RESULTS REC'D: 98/12/14 21:27
RESULTS READ :

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date & Time	Date of Service

	Nutrition Note 12-21-98
INNT	① IMPACT 110 cc qh
	24 y.o. ♂ S/P GSW abd + chest, hepatorraphy, HX, Hepatic artery repair, Cholecystectomy
	Ht 182 cm Wt 143 kg on admit Adj 98 kg
	Prealb 7.2 UUN = 22 gm/24h
	S/P drainage intrahepatic b. loma.
	A Est Needs (REE X .75) 2800 Kcal, 180 gm Protein to continue healing, maintain ⊕ N balance providing abundant energy source is 166 % IBW ♂. No anabolic trends yet.
	PLAN ① IMPACT 110 cc qh
	② p.o. Feeds soon ? High kcal High Protein diet is the ultimate goal.
	③ Wt bearing activity to maintain body cell mass.
	M'Duyer RD 22117
12-22-98	Nursing Summary 7P.1A
	300 cc from new hepatic drain. Pt requiring more pain medicine due to Changes ⊕ side pain. NO other changes to note. Wilson

Date of Service

Date & Time	
12/22/98	STICU HD 16
	Neuro: A/A, FC, MAE
	Pulm: RR 28 96% SaO2 2L NC
	CTA (B)
	CV: P 125 MAP 106 ~~RRR~~
	RRR Hgb 9.1 Plts 829
	FEN: I/O 3.8/4.8 Uo 4.3
	129 | 91 | 14 < 147 CT 80 ø blk
	4.2 | 30 | 0.6 IHDrain 500 SHDrain ø
	Abd soft ⊕ BS, granulating Impact TF's @ 110cc's/h
	ID: Tm 38.8 WBC's 18.6 (19.8)
	Vanc[4] / Gent[7] / Levo[4]
	A/P Intrahepatic abscess / necrosis -
	cont drainage / abx
	Hyponatremia - if cont to ↓, fluid restrict
	[signature] MD

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	
12/22/98	GI c Dr. Scott.
	Subdiaphragmatic tube s drainage
	500 cc output from the intrahepatic drain.
	CT - 80 cc
	Tm: 38.8 P: 117 BP: 120/80 R: 20 Pulse-Ox 96% 2L NC
	abd: soft ↓ BS.
	S/p intra-hepatic drainage yesterday.
	There is no e/o a pleuro-biliary leak.
	Pt. getty better overall. Resp. status improving
	There is no indication for an ERCP/stent
	placement @ this time.
	Will s.o. Please re-consult w/ if we can be of
	further assistance
12-22-98	P.T. Note
1:30pm	S: A/Ox3. Good spirits. Anxious to get up.
Ex 1	O: Ex per flow sheet.
	A: Pt tolerated Rx very well c min S.O.B.
	Should be ready to ambulate when
	ordered.
	P: Cont
12/23/98	IR Staff -
1:30	1000 cc drainage from new drain
	WBC slowly falling & Temp also returning
	to N
	Continue drainage.

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Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
	STICU
12/23/98	HD 17
	Neuro: A/A, FC, mute
	Pulm: RR 32 SaO2 94% on 2 LNC
	CTA (B)
	CV: P 125 MAP 104 RRR
	Hgb 9.2 Plts 854
	FEN: I/O 4.0/5.4 U. 4.8
	133 | 97 | 16 < 132 ; 4.1 | 25 | 0.7 — CT Bo ø blk
	SLDr ø IHDr 400
	Abd soft, granulating ⊕ BS [illegible]
	ID: Tm 38.5 WBC's 20.2
	Vanco 5 / Mero 8 / Levo 5 Enterobacter / Enterococcus / E coli
	A/P: Hepatic abscess / biliary leak
	cont. drainage & abx
	Transfer to IMU
	[signature], MD

Date & Time	Date of Service
12/23/98 0740	IR ~~Pt~~ Tmax 38.F T curr at 38 WBC - 20? (18.6) Drain output - Intrahepatic - 400cc (500) Suprahepatic - Ø (0) WBC ↑ c fever. - ? source Rec. re-CT at some point to access drainage of fluid Dale R Alsher MD 404-3679
	Examined patient & improving It is time to remove non draining tube. Will D/W Trauma Service [signature]
	Drain flushed which reveals brownish particulate material. Will need to flush q shift c saline. Dale A Isher, MD 404-3679

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	Physical Therapy Reassessment
12/25/98	S- "my (R) side when the chest tube is really hurts"
	(pt's HR 130 while resting in supine)
Reass. 2	O- pt ROM to (B) LE WFL.
Ex-1	MMT (B) LE grossly 4+/4+ 4/5 (pt's HR ↑ from 130 to 144° c̄ active movement.
	Bed mobility - supine → sit c̄ HOB at 60° c̄ min (A) (pt's HR ↑ from 132 to 150 c̄ supine → sit).
	pt sat in EOB for 5 min until HR ↓ to 140.
	pt sit → stand from EOB c̄ min (A) (pt's HR ↑ from 140 to 150-165)
	pt stood c̄ CTG for 1 min.
	pt return to supine c̄ min (A).
	pt performed x 10 reps LE exercises of SLR & hip AB/AD.
	A pt is improving in strength & mobility since initial eval on 12/13/98. pt is limited at this time 2° ↑HR, endurance, and pain (chest tube)
	pt c̄ current Goals 1) pt supine → sit c̄ SBA/CTG.
	2) pt sit → stand c̄ SBA/CTG.
	3) pt is able to march in place for 1 min x 2 reps.
	P continue c̄ exercises, bed mobility, transfer, & standing activities as pt is able to tolerate.
	[signature] PT

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date & Time	12/23/98	Date of Service

Your patient has been evaluated by the Respiratory Therapy Consult Service. Based on the clinical indicators derived from the following assessment, the Care plan designated below will be implemented

Breath Sounds	Breathing Pattern	Cough	Sputum Production	Mobility
☑ clear ☑ diminished ☐ fine ☐ coarse ☐ wheezes ☐ absent ☐ stridor	☑ nonlabored ☐ labored ☐ shallow ☐ irregular ☑ rapid ☐ mech. vent.	☑ strong ☐ fair ☐ weak ☐ absent	☐ none ☑ sm. amt. ☐ mod. amt. ☐ lg. amt. Consistency/Color ☐ thin ☐ mod. ☑ thick Yellow	☐ ambulatory ☑ up w/ assist ☐ bed rest ☐ paraplegia ☐ quadriplegic

Mental Status	Chest X-ray	Vital Signs	Lab	Lung Volumes
☑ alert ☐ obtunded ☐ confused ☐ unresponsive	☐ clear ☐ infiltrates Bilateral Lobes ☑ atelectasis ☐ pleur. effus. ☐ pulm. cont. ☐ rib fx ☐ not avail.	HR 130 RR 24 BP 140/85 Temp 38.3	WBC 20.2 Hg 9.2 SpO2 96%	Actual PF IC VC Predicted PF IC VC

431485

RESPIRATORY CARE PLAN

Medicated Aerosol Therapy NEB MDI IPPB Frequency ____
Aerosolized Medication: ____
Volume Expansion Therapy IS (IDB) Frequency q4°

Bronchial Hygiene Therapy PD Perc IPV Frequency ____
Spinal Cord Protocol: ____ Frequency ____
Oxygen Therapy FIO2 LPM Delivery Device ____

Comments

Will continue IDB as ordered · pt. instructed to do IS on his own — Q Critical Care

Date & Time	Date of Service
12/23	Nsg Summary & transfer. Neuro: AAOx3, MAEW x4. CV: tachycardic ē ectopy. VSS. Resp: 2LNC O₂ ... diminished ... ē crackles. TPPB Q4° rate 28-32. GI: Ⓡ hepatic drains x2. Abdomen large, round. semi soft BM x ... NJ ... infusing ... @110cc/hr. GU: u/o adequate. Cl. liq. diet. Skin: ... A'd ... well
12/23/08	Nurse Liaison Note Spoke to pt. condition update given importance of respiratory toilet addressed. Plan of care addressed which included transfer to SICU. ~~....~~ what to expect in SICU discussed. All questions/concerns addressed. Jane [signature] 22329

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Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	TRAUMA
12/24/98	Tm 100.2 Tc 98.7 BP 131/81 P 114 I/O 3650/1915
6 30	Pt s c/o
	Lungs: Coarse BS (B) CT: 45cc / ø air leak
	CV: RRR ø m
	Abd: hypoactive BS, NT, soft, wound healing
	Drainage 40cc / 100cc
	WBC 18.0
	Temp Resolving Suprahepatic abscess
	Plan Cont Abx. [signature] 23264
12-24-98	Physical Therapy
0930	S: ø
2R	O: now in SIMU ; seen supine in bed , lines and tubes intact , awake ; SpO2 100% HR 120's ,
	supine → sit - SBA c HOB 30° and c use of rail
	sat EOB x 5 min . then ~~transferred~~ stood up c SBA
	to urinate ; assisted to BSC then to chair c
	CGA A: ø distress nor difficulty breathing ;
	will start ambulation once CT to thoracic seal
	P: cont [signature] - VALSMONSANTO 23854

Date & Time	Date of Service
	TRAUMA MED:
12-24-98	DISCUSSED C DR FLOYD
	Tm x100.2 BP 130/80 P 115 R 18
	I-O: 3650/1915 ; C.T. 75mL; INTRAVENOUS - 100mL
	INTRAPERITONEAL 40mL
	TUBE FEEDS: 110mL/HR
	CLEAR LIQUID DIET
	ANTIBX: GENTA; METRONIDAZOLE; VANC
	(ENTEROCOCCUS, ENTEROBACTER, STAPH)
	PLAN: C.T. ABD
	CXR
	DUKE
12/24/98	ICU Staff
1300	Drainage decreasing 40 cc/100 cc
	Tm still elevated at 100.2
	WBC - 18,000
	Eating / hungry
	Imp: Improving
	Agree c plan of Dr Duke

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	
	TRAUMA
12/25/98	Tm 100.6 130/84 I/o 4605/2855
6[30]	Tc 99.1 P 112 Sup hep drain 100 CT 40
	Lungs: CTA @ hep drain ø
	CV: S, S2 ø
	Abd: soft, NT, +BS, +BM, Jejunostomy leaking
	TF @ 100 cc/hr
	Temp improving
	Plan CT Abd today c contrast
	CXR
	D/C CT
	2326
12-25-98	TRAUMA MED
	Tmx 100.6 BP 130/84 P 112 Tc 99.1
	I-O: 4600/2855 C.f. 40mL; SUPRAHEP. 100mL
	INTRAHEPATIC DRAIN ø
	C.f. NPO NG Dwc
	TUBE FEED: 100 mL/hr
	NPO
	SaO2 100%; 2 liters NASAL - RESPIRATORY
	WBC 10.2 - DIFFERENTIAL; C.f. REMOVED
	PAN. C.f. NPO
	TRANSFER FLOOR
	DAH

Date of Service

Date & Time	IR note
12/25/98	Pt refers doing well
3:15 pm	Tmax 100.6
	suprahepatic drain: φ
	intrahepatic drain: 400cc's of bloody bile.
	A/P: continue flushings and if φ drainage might consider d/c tube.
	EA 03919
12/26/98	Trauma
	CT done [illegible]
	101 142/78 P112 5380/4705 [illegible] 50/210
	chest CTA
	Heart [illegible]
	Abd [illegible]
	[illegible]
	[illegible] CT
	CT [illegible]
	[signature]

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	
12/26/98	CT of Abdomen c IV Contrast (Post drainage of liver Abscess) - ↓ fluid in Rt lobe liver compared c 12/12/98 - Rt lower lobe pneumonia - Lt Subsegmental Atelectasis - Drainage tubes present
12/26/98 14:05 2Gt.	Physical Therapy S: "I'll feel better when my tubes out of my side." O: Pt. trans. supine → sit c mod (I). Amb. 150' c HHA. Returned to bed c mod (I). Encouraged pt. to sit up OOB + Amb. c family + nursing staff. A: Pt. a little unsteady - ↑ gait distance. P: F/U on Monday. Sup. PT: G. Valenzuela /K. Olay PTA 25432
12/[illegible]	

Date of Service

Date & Time	
12/27/96	Trauma
	[illegible] fl [illegible], tol po, ambulating
	99.8 124/76 P109 S637/4250 Drain #1) 180
	chest CTA #2) 450
	Heart [illegible]
	Abd soft [illegible]
	Imp continue [illegible], tol diet
	[illegible]
	Blue team. [illegible signature]

430016 (Back Page)

HERMANN HOSPITAL

Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
12/27/98 WANG	Trauma Staff
	99[8] / VSS 5637/4250
	450 – Syn-hepatic, JP's → bilious
	430 – yellow [illegible]
	[illegible] / Vanc / [illegible]
	JP's @ [illegible]
	[illegible]
	[illegible] well.
	[illegible]
	[illegible] (signature)
12/28/98	Trauma
	[illegible]
	100.3 148/93 P123 4550/3310 [illegible]
	chest CTA
	Heart [illegible]
	Abd [illegible]
	134/98/15 149 ALT 85 T. 5.1 / 0.6 14.1 88 26.8 845 2 [illegible]
	96/31/0.8 AST 48
	Alk 88
	[illegible] (signature)

Date & Time	Date of Service
	IR Note
12-28-98	Pt. refers doing well.
7:55AM	Tmax: 100.3 Tc: 99.4
	suprahepatic drain: 360 cc's
	inferior hepatic drain 200 cc's
	WBC: 14.1 ↓ (12/27)
	AP: continue to monitor drainage output.
	DRAINS c̄ CONT, SITE OUTPUT - CONSIDER RE-IMAGING
	@ SOME POINT, BY LAST CT SOME IMP. [signature] 23919. [signature]
12/28/98	Physical Therapy
09:25	S: "I walked to the RR & back."
2FA	O: Pt. seen ⓢ bedside.
	Supine → sit c̄ Mod (I).
	Amb. ~ 600' c̄ SBA
	Returned to bed c̄ Mod (I).
	A: Pt. occasionally unsteady - but able
	to right himself.
	↑↑ gait distance. Encouraged pt. to
	amb. c̄ nursing staff 2° P.T. only
	able to see pt. QD. Pt. is high level -
	no reason a nursing tech. couldn't walk
	him.
	P: Will see pt. X1 for high-level balance
	activities. Cont
	Sup. PT: G Valenzuela / R. Oliy PTA 23432

430016 (Back Page)

HERMANN HOSPITAL

Pt. H&P / Prog Notes

Wilford, Kerne

2014

Date of Service

Date & Time

TRAUMA ATTENDING NOTE - Date 12/28/98 PATIENT Wilford 553

Patient seen, examined and discussed with ✓ Trauma Team, __ ICU Team; Specifically reviewed plan with Dr. [illegible]

System	Comment	Plan
	S/p GSW to abd	
	100³ USE Vanc / Gent / Oflx	↓ enteral steps, [illegible]
	WBC 14.1 (↓'d)	
	2 percut drains 200cc / 360cc	
	CT 1 abd drain good drainage	
	tolerating regular diet	
	[illegible]	

Signature: [signature]
Christine S. Cocanour, M.D.

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(713) 792-5235

PT NAME: WILFORD ,KANE **
DOB: 05/14/1974 AGE: 24 SEX: M
MR#: 96925490 9367 STATUS: IA

ORD'D BY: DUKE, JAMES H. (TRAUMA)
DT PERF: 12/13/98 AT 03:12 HRS.
REQUISITION NO: 01232038
MED RECORDS (CHART) COPY

N/S: STIC RM/BD: STIC19 OR VISIT CLINIC:
INDICATIONS: OPN WOUND SITE NOS-COMP

EXAM(S) PERFORMED: CHEST 1 VIEW (110 KV @ 8.0MAS)

CLINICAL INDICATION: Endotracheal tube placement.
PORTABLE AP SUPINE CHEST, 12-13-98, 0330 HOURS:
****
IMPRESSION:
Bilateral patchy alveolar infiltrates not significantly improved. The right-sided chest tube is stable in position. There is interval placement of an endotracheal tube at the level of the medial ends of the clavicles and a left subclavian line within the superior vena cava. A previously noted Dobbhoff tube has been removed. There is interval placement of a nasogastric tube.
****
Comparison with 12-12-98.

READ RADIOLOGIST:
ATTN MD: DUKE, JAMES H. (TRAUMA) RESIDENT:
APPROV RAD: RESULTS REC'D: 98/12/14 08:19
RESULTS APPROVED: 12/13/98 03:12 RESULTS READ :

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	
	Occupational Therapy Note
12-28-98	S: "I'd like to get some clothes on".
1200	O: Pt. seen for therapeutic ex's BUE's
2ND	+ hand gripper ex's. Instr. in EOB
	for T-band ex's.
	A: Pt tolerated ex's well. Mildly depressed
	but motivated.
	P: Cont. Rx.
	Brent Bartlett, OTR
12/28/98	Case Management
1235	Chart reviewed per cont. med necessity. Sandra Winn RN
	22410 →
12-29-98	IR Note
7:40 AM	
	Pt reports feeling well.
	Tmax 100.2
	suprahepatic drain 400 cc's
	infrahepatic drain 60 cc's (↓)
	A/P: F/u on drainage output
	Kimbrough
	STAFF
	PROGRESSING + IN OUTPUT FROM 2394 INTRAHEP COLLECTION
	SUBPHRENIC COLLECTION WITH CONT HIGH OUTPUTS
	PROB CONT COMM C (R) THORAX CONSIDERING CMV
	DIM. AMT OF FLUID AROUND LIVER ON CT 12/25

Date of Service 12/29/98

Date & Time	Physical Therapy
12/29/98	S: c/o some "side pain."
09:05	O: Pt. seen @ bedside.
2FA	Amb. ≈ 300'
	Worked on one leg stance in ll bars.
	Pt. rode stationary bike ≈ 4 min
	Took a 5 min rest. returned to room
	A: Gait a little unsteady today.
	Only able to one leg stance ≈ 5 sec
	per leg
	P: Will cont to see pt. until d/c.
	Sup. PT: R. Dizon 23432 R. Olay PTA
12/29/98	Occupational Therapy
1140	S: "Is it always going to be like this"
1AT, 3ND	O: Pt. seen for ADL's dressing, ambulated
	to rehab gym + performed
	UE endurance ex's @ 4 lb wt.
	Pt. had to ride back in w/c,
	used toilet p Rx.
	A: Pt. dressed self c shoes which
	required min A. Fair tolerance
	to Rx. Poor endurance.
	P: Cont. Rx.
	[illegible], OTR

HERMANN HOSPITAL

Pt. H&P / Prog Notes

2014

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WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date of Service

Date & Time	

TRAUMA/GENERAL SURGERY ATTENDING NOTE

Date 12/29 Patient Wilford

Pt seen, examined & discussed with Dr. Floyd

System	Comment	Plan
Neuro	A+A, FC	
Pulmonary	Stable	Clear B S
C.V.	106/85, P=102	Ⓑ lower lobe Atelectasis
ABD	Reg Diet	Blood
	granulation wound	Aggressive Pulmonary
I/O	=1930/2080	Care → Intrapericardial
TM	= 100.2	Subphrenic Abscess

Frederick A. Moore, M.D. Day 11 of 14 Antibiotics

Vaneo / Cefepime Levoquin

[signature]

12/30/98 Trauma

[illegible]

101 143/77 Ⓑ 112 2230/2650 [illegible] #1 [illegible]

chest CTA 50 #2

Heart [illegible]

Abd soft, wound healing well

[illegible] Abx

[signature]

12/30/98 1030hrs Case Management: Chart Reviewed. Clinical called to Susan McGregor ī up-date. Will follow today. — Linda Buehner [illegible] 23132

Date of Service

Date & Time	Physical Therapy
12/30/98 09:40 2FA	S: "I'm so weak." "When will I feel stronger" O: Pt seen @ bedside. Min (A) c dressing. Amb. 300'. Worked on one leg stance. Felt dizzy - Returned to room via w/c. A: ↑ one leg stance ≥ 11 sec per leg. ↓ endurance today. P: Cont Rx. PT: B. Valenzuela / R. Otey PTA 1345
12/30/98 11:45 2ND IAT REACHER Bathe Sponge	Occupational Therapy S: "I will have my girlfriend & also my relatives dressing me.... and helping me at home." O: Pt seen by O.T. for ADLs & B UE strengthening exercises. Pt performed exercises using red theraband & hand gripper for 2 sets x 20 reps ea. Pt performed ADLs (i.e. dressing - LE & UE). Pt was provided c reacher to (A) c LE dressing when pt is fatigued & LH bathe sponge to (A) c bathing. A: (A) did not want to go out of room. Pt performed ex @ bedside. Pt reported he can get in & out of commode (I). Pt will require a shower chair to utilize during showering. Pt required many rest breaks this A.M. Pt reported she is stronger some days, but today she's ~~little~~ much weaker. Hx of CVA P: Continue O.T. Romenia Rayfield, LOTA

430016 (Back Page)

HERMANN HOSPITAL
Pt. H&P / Prog Notes

2014

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

ATTN. M.D

12/30/98 Resp Assessment

Date & Time	Date of Service

Your patient has been evaluated by the Respiratory Therapy Consult Service. Based on the clinical indicators derived from the following assessment, the Care plan designated below will be implemented

553

Breath Sounds
- [x] clear
- [x] diminished
- [ ] fine
- [ ] coarse
- [ ] wheezes
- [ ] absent
- [ ] stridor

Breathing Pattern
- [x] nonlabored
- [ ] labored
- [ ] shallow
- [ ] irregular
- [ ] rapid
- [ ] mech. vent.

Cough
- [ ] strong
- [x] fair
- [ ] weak
- [ ] absent

Sputum Production
- [x] none
- [ ] sm. amt.
- [ ] mod. amt.
- [ ] lg. amt.

Consistancy/Color
- [ ] thin
- [ ] mod.
- [ ] thick

Mobility
- [ ] ambulatory
- [x] up w/ assist
- [ ] bed rest
- [ ] paraplegia
- [ ] quadriplegic

Mental Status
- [x] alert
- [ ] obtunded
- [ ] confused
- [ ] unresponsive

Chest X-ray
- [ ] clear
- [ ] infiltrates
- [ ] atelectasis
- [ ] pleur. effus.
- [ ] pulm. cont.
- [ ] rib fx
- [ ] not avail.

Vital Signs
HR 120
RR 20
BP _____
Temp _____

Lab
WBC _____
Hg _____
SpO2 _____

Lung Volumes
Actual: PF ___ IC ___ VC ___
Predicted: PF ___ IC ___ VC ___

RESPIRATORY CARE PLAN

431485

Medicated Aerosol Therapy NEB MDI IPPB Frequency _____
Aerosolized Medication: _____
Volume Expansion Therapy IS IDB Frequency QG
Comments A to W/A

Bronchial Hygiene Therapy PD Perc IPV Frequency _____
Spinal Cord Protocol: _____ Frequency _____
Oxygen Therapy 21% FIO2 LPM Delivery Device R.A.v

SaO2 96% on RmAir

Resp orders have expired 12/28/98
New orders are needed to cont.
Tx.
New Resp Orders are needed LeRoy Lowe

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date & Time	Date of Service
12/31/98	Transp Ri
	[illegible]
	100° 139/74 ⌀ p114 1980/1690 Drain #1 [illegible]
	chest CTA #2 490
	Heart [illegible]
	Abd soft, NT, BSNA
	Dressing C/D
	[illegible]
	D/C home [illegible]
	[signature] 24289
1/31/98	JR Note
	Tm 100° Tc 99.4
	Pt refers doing well.
	Drain #1; suprahepatic ⌀
	Drain #2; infrahepatic 490 cc's
	A/P: Please flush drains twice a day
	Follow output of drains
	[signature] 23914
12/31/98	08am Case Management
	Chart reviewed. Please page for any additional home health
	needs. Home health set up by Susan McGregor @ 713-741-
	2273 Ext. 5775. I will follow today. Linda Buehner RN 23132

HERMANN HOSPITAL
Pt. H&P / Prog Notes

96 92549 0 9367
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

2014

Date of Service

Date & Time	
	TRAUMA ADD
12/31/98	DISCUSSED W/ DR FLOYD
	TMAX 100.6 BP 139/74 PLS
	I-O 1480/1690 INTAKE-490, OUTPUT-0
	RED DIET -
	AMBULATING
	WOUND: CDEW-CLEAN.
	NO ANIBX-
	PLAN: DC NJ/IVF
	DC CENTRAL LINE
	BELOW WOUND CLOSURE
	DUE
12/31/98	Physical Therapy
14:35	S: c/o side pain
2FA	O: Pt. donned clothes
	Amb. ≈ 400' c SBA.
	Rode stationary bike x 2 min.
	A: Pt. do well - but has been
	laying in bed too much -
	Encouraged pt. to sit up OOB
	to ↑ his endurance
	P: Cont Sup. PT: E. Chambers
	R. Olympia
	03482

96 92549 0 9367
WILFORD , KANE **
BM Age- 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

Date & Time	Date of Service
	Occupational Therapy
12·31·98	S: "I'm going home."
1620	O: Pt. seen for ADL's using LE equipment
IAT	& advice to avoid stress to abd.
IFE	area. Pt. advised to ~~to~~ attempt
	A: Pt. (I) in LE dressing & equipment
	but states will have help.
	Endurance remains poor.
	P: Pt. to D/C home. Recommend
	home safety eval
	Geri Burkel, OTR

430016 (Back Page)

HERMANN HOSPITAL
Anes Rec OR

96 92549 0 9367
WALTER ,KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

2009

NAME: Gunshot wound Abdomen. — I D Number
PreOp DX/ICD 9 CODE: Exploratory laparatomy, ligation of
OPERATION/CPT CODE: hepatic artery, Cholecystectomy

DATE: 12-7-98 — ATT SURGEON: Duke — WT 162 kg. — AGE 24 y.o. — ALLERGIES NKDA.

ANES CARE TEAM #1 — Start 0110 — End 5:00 — Att Wilhite — Res Dogan
#2 — Start — End — Att — Res.

ASA 1 2 3 4 5 E — PT IDENTIFIED ☐ — CONSENT ☐ — CHART REVIEWED ☒
LAST PO INTAKE unknown — OR# 21

TIMES: ANES START 0110 — PREP — OP START 0204 — OP END — END ANES 5:20

☒ GENERAL ☐ MAC no DRUG ☐ MAC with DRUG ☐ REGIONAL ☐ LOC BY SURG

LINE (SIZE & LOCATION) PLACED
☐ CVP ☐ PA ☒ ART 20G L RA ☒ IV 14g ☒ IV 16g ☐ IV

☒ INDUCTION ☒ IV ☐ INHAL ☐ RECTAL ☐ IM ☐ OTHER ☐ PRE O2 ☐ CRICOID PR.

☐ MASK ☐ LMA ☐ AIRWAY ☐ ORAL ☐ NASAL — ETT# 8.0 at 22 cm — LEAK at cm
☒ ORAL ☐ NASAL ☐ TRACHEOSTOMY ☐ TOPICAL DRUG % ml ☐ TRANSTRACHEAL DRUG % ml
☐ AWAKE ☐ RAPID SEQUENCE ☒ DIRECT VISION ☐ BLIND ☐ FIBEROPTIC ☒ STYLET ☒ BLADE/MAC ATTEMPTS 1 ☐ DIFFICULT WHY

☐ BILAT = BS ☒ CO_2 TRACE ☒ SEMICLOSED CIRCLE ☐ NON REBREATH
SPECIAL TUBE ☐ DOUBLE LUMEN ☐ LASER ☐ RAE ☐ ANODE

TIME	0100	30	0200	30	0300	30	0400	30	0500	TOTALS
① Fentanyl 50 µg / ② Cefoxitin 2g										
Temperature °C		36.1	35.7	35.9	35.9	36.4	36.2	36.3		
Rhythm II	ST	ST	ST	ST	ST	ST	ST	ST		
CVP/PCW/C.O.										
O_2/Air	10/0	10/0	10/0	10/0	10/0/1/1	0.8/1	0.8/1	8/0		
STP mg		500								500
Sux mg		120								120
Roc. mg		50			30, 20					100
Ephedrine mg		10,	20	5						30
NaHCO3 meq			50, 50							100
Epinephrine mcg			10 10	10						30
Isoflurane % E				0.6	0.8	0.9	0.7			
Vent Rate/Vol	SV	10/1.00	10/1.10	10/1.06	9/900	10/850	12/850	CV		
Pip/Peep		36/3	35/3	35/4	32/2	35/2	38/2			
$ETCO_2$		45	44	43	45	46	41			
$FiO_2/O_2SAT\%$		1/82	1/88	1/89	.4/100	.4/100	.4/100	1/100		
RBC	IU	2	3 4	5	6 7 8					8 units
FFP/Colloid		Hesp								2 Hesp, 2 units FFP
Crystalloid	1000									5000
Est. Blood Loss			1000							2000
Urine				400	240	260				900
Other Lab			7.32/44/394/23/-3			7.24/52/111/22/-5		H/H: 12.2/36.7		

Na: 136 K: 3.9 Glu. 289 H/H: 8.4/24.6 — Na: 136 K: 5.2 Glu: 261

Anesthesia legend: START x, FINISH ⊗; T INTUBATION; P PREP; ⊙ OP START; ⊙ OP END; EX EXTUBATION; B P: v SYSTOLIC, ^ DIASTOLIC, X MEAN, • HEART RATE; Tourniquet up T'; Tourniquet down T.; RESP: O Spont., AR Assisted, CR Controlled.

PRE-INDUCTION B/P = P = RA SAT =

Attending Attestation: Pt Hx-Pre evaluation reviewed. Anesth Plan Read. Present for induction, intubation, during anesth / resuscitation

☒ EQUIPMENT CHECKED AND FUNCTIONAL
☒ BP CUFF SITE LUE
☒ EKG LEAD II
☒ STETHOSCOPE ☒ PRECORDIAL ☒ ESOPHAGEAL
☒ TEMP SITE Esop.
☒ FiO_2 MONITOR
☒ PULSE OXIMETER ☐ EEG
☐ PA OXIMETER ☐ TEG
☒ CAPNOGRAPH/AGENT MONITOR ☐ TCD ☐ SONO
☒ VENTILATOR
☐ NERVE BLK MONITOR

POSITION Supine
PRESSURE POINT CKD
TEMP CONTROL — EYE CARE
☒ HUMIDIFIER ☐ OINT
☐ BLD WARMER ☒ TAPE
☐ LIGHTS
☐ HEATERS ☒ NG TUBE
☐ HUGGERS
☒ BLANKET ☐ HYPOTHERMIA
☐ OTHER

REGIONAL: EXTREMITY/LOCATION
☐ SPINAL ☐ CAUDAL ☐ EPIDURAL ☐ CSE ☐ CATHETER
☐ PUMP ☐ INTRATHECAL NARCOTICS ☐ OTHER
NEEDLE/SPINAL g ☐ Q ☐ S ☐ W EPIDURAL g
POSITION — SITE/ATTEMPTS
PARASTHESIA ☐ Yes ☐ No / SPECIFY
BLOODY TAP ☐ Yes ☐ No CSF: BEFORE — AFTER
EPIDURAL SPACE DEPTH cm CATH INSERTED cm
OPIOIDS/DOSE SPINAL — EPIDURAL
EPI/DOSE SPINAL — EPIDURAL
COMMENTS
SET/LOT#
STAGE OF LABOR ☐ I ☐ II SVE
UTERINE INCISION TIME — DELIVERY TIME

Present for anesthesia. Right art line. [signatures]

REGIONAL BLOCK	1ST INJ	2ND BOLUS	3RD BOLUS	INFUSION
TIME				
DRUG/CONC				
TEST DOSE				
VOLUME				
SENS LEVEL/MOTOR				

CATHETER OUT: INTACT — TIME — POST OP ANALGESIA: ☐ YES ☐ NO

TRANSPORTATION TO: ☐ PACU ☒ ICU ☐ OTHER
RELAXANT REVERSED: ☐ Yes ☒ No ☐ TOF ☐ HEAD LIFT
☒ EKG ☒ PULSE OX ☒ ETT ☒ AMBU ☒ O2
VENT: ☐ SPONT. ☒ CONTRL ☐ ASST.
RECOVERY ROOM: BP 117/84 P 172 R 10 SaO2 100%
O2: ☐ NASAL ☐ MASK ☒ T. PIECE ☐ CPAP
CONDITION Stable

434214 (6/95) Page 1 of

3 518872

MEDICAL RECORDS

96 92549 0 9367
WALTER , KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

PRE-ANESTHESIA EVALUATION

PRE-OP DX: GSW to chest abdomen
PROPOSED OP:
DATE 12/7/98 TIME 0100
☐ ELECTIVE ☒ EMERGENCY
MENTAL STATUS: ☒ ALERT ☐ OTHER
ASA STATUS: 1 2 3 4 (5) E
☐ INSTRUCTED NPO 6 HRS.
☐ LAST SOLID INTAKE 23xxxx ☒ LAST LIQUID INTAKE 2300
WT.: 399 lbs HT.: AGE: 24y SEX: M
TEMP: BP: 97/66 P: 122 RESP.:

PRE-MED | TIME | ROUTE
1.
2.
3.
4.

MEDICATIONS
1.
2. None
3.
4.

ALLERGIES
NKDA

ANESTH. HX
GA & complications

FAMILY HX (Anesth. Problems)

SIGNIFICANT PROBLEMS

MEDICAL HX/SYSTEM REVIEW

RESP: ☐ COUGH ☐ ASTHMA (R) CT ☐ COPD ☐ SMOKING ____ PPDX ____ YRS. ☐ VENT. DEPENDENT ☐ SOB — denies
CV: ☐ CHF ANGINA 3 - 2 - 1 (0) good ☐ EXERCISE TOLERANCE ☐ HTN (16g & 14g) 2 peripheral IVs ☐ MI ☐ MURMUR/ARRYTHMIA — denies
GI: ☐ PUD ☐ HIATAL HERNIA ☐ REFLUX — denies
METABOLIC: ☐ OBESITY ☐ DM ☐ STEROIDS ☐ SICKLE CELL ☐ THYROID — denies
RENAL: denies
2 units O(-) received
& 4L of fluids
LIVER: ☐ JAUNDICE ☐ HEPATITIS ☐ ETHANOL ☐ BLEEDING (= / -) — denies
NEUROLOGIC: ☐ TIA ☐ SPINAL CORD ☐ SEIZURE ☐ CVA ☐ ICP ☐ NEUROPATHY ☒ GCS 15 ☐ MYOPATHY — denies
PREGNANT: ☐ YES ☐ DENIES ☐ LMP
OB HX: GRAVITY ____ PARA ____ GEST AGE ____ BIRTH HX:
FETAL RISK: ☐ NORMAL ☐ DISTRESSED ☐ COMPROMISED

PHYSICAL EXAM
AIRWAY: CLASS II
DENTAL STATUS ☐ DENTURES ☐ CAPS ☒ TEETH Loose
NECK MOBILITY Free
MOUTH
LUNGS: CTA bilat anteriorly
HEART: Tachycardic
BACK/EXT:

SIGNIFICANT LAB
Hb / Hct 12.6 / 36.3 EKG
Na / K 137 / 3.5 CXR
Glucose 173 COAG
BUN / Creat. 14 / 1.5 Units T&S / T&C

ANESTHESIA PLAN
☒ GENERAL ☐ REGIONAL ☐ MAC
WILL ACCEPT BLOOD: ☒ YES ☐ NO
RISK/BENEFITS DISCUSSED AND ACCEPTED:
☒ PATIENT ☐ PARENT ☐ OTHER
COMMENTS:
12/7/98 Pt is H&D Preanesth evaluation reviewed by Anesth & Resuscitation plan approved

Oya Dogan 24654
RESIDENT SIGNATURE
FACULTY SIGNATURE

RECOVERY ROOM NOTE DATE: 12/7/98 TIME: 5:00
Pt transferred to STICU remained intubated, on vent. Hemodynamically stable
Oya Dogan 24654
RESIDENT SIGNATURE

POST-OP VISIT DATE: 12/7/98 TIME: 10:00
Pt is awake, alert, following commands - Intubated, weaning - VSSS. No apparent anesthesia complications
Oya Dogan
RESIDENT SIGNATURE

HERMANN HOSPITAL

Operating Room Record

Or Rec

3005

96 92549 0 9367
WALTER ,KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

Surgeon: DUKE
Assistants:
1. BEYERS
2. PETERSEN
3.
4.
5.

Time Scheduled: NOW | Case Priority: C | O.R. 20 | Date: 12/07/98

Anesthesiologist: WILLITE | Resident / CRNA / SRNA: DOGAN | CHABRIA MD

Anesthesia: None | General | Block | Local | Stand-by | EPI Spinal

Pre-operative Diagnosis: GUNSHOTS TO BACK - LEFT SHOULDER - ABDOMEN & RIGHT CHEST.

Operation(s): EXPLORATORY LAPAROTOMY - LIGATION OF HEPATIC ARTERY. CHOLECYSTECTOMY. DEBRIDEMENT OF F.B. ENTRY X 1

Post-operative Diagnosis: SAME AS ABOVE

Laser | Microscope

Scrub Nurse/Technician

B. BAKER	0110	0315
M. CHEER	0315	0420
B. BAKER	0420	0445
		TO
		TO
		TO

Circulating Nurse

A. MACHUCA RN	0110	0445
		TO
		TO
		TO
		TO
		TO

Time patient arrives Holding Area: In O.R. 0120

Anesthesia Time: 0120 - 0445

1st Resident Arrival Time: 0120

Surgeon Arrival Time: 0130

Time of operation
1. 0204 - 0430
2. ____ - ____
3. ____ - ____
4. ____ - ____

[01] C.V. [02] E.N.T [03] Eye [04] G.S. [05] G.U. [06] Gyn [07] Neuro [08] Ortho [09] Pedi [10] Plastic [11] Thoracic [12] Hand [14] Procto [15] Renal Trans. [16] Other [16] Burns [16] Trauma [13] Maxillo-Facial

Sponge Count
Initial by: BAK S. MACHUCA.

Closing by:
1st: Correct/Incorrect CHEER M. MACHUCA R.
2nd: Correct/Incorrect CHEER M. MACHUCA R.

Change of Shift by: Correct/Incorrect/N.A.

Additional By: Correct/Incorrect N.A.

Lap Sponges	O.R. - 4x8	Peanuts	Cottonoids	Needles	Other
10-10	10			13+2+2+2	

431943 9/95

Operating Room Record

HERMANN HOSPITAL
Or Rec

96 92549 0 9367
WALTER , KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

ID Bracelet position:
Pre-op: (L) WRIST Post-op: (L) WRIST
Consent: Yes ☑ No ☐
Prep Betadine ☑ Shaved: Yes ☑ No ☐ Phisohex ☐ Other ☐
O.R. 20 Date: 12/10/98
Skin Pre-op: WARM-DRY - FOREIGN BODIES ENTRIES-X4 T 35°
Skin Post-op: Sutured ☐ Stapled ☑ Steri strip ☐ Open ☑ DRESSED - BOWIE SITE CLEAR
Operative Position & Aids: Safety Strap Yes ☑ No ☐ OVER PADDED ~~TH~~ LOWER LEGS - SUPINE C BOTH ARMS EXTENDED ON PADDED ARMBOARDS x SECURED. PLASTIC BAG OVER LOWER LEGS - BEAN BAG UNDER PATIENT. HEAD ON FOLDED BLANKET
Indwelling Catheter Pre-op: FOLEY 16 TO URIMETER
Intra-op: MAINTAINED
Nitrogen: Drill ☐ Dermatome ☐ Drill ☐ Other ☑
Hypo/Hyperthermia Unit Type: _____ Serial # _____ Temp: _____
N.G. Tube Pre-op: NONE
Intra-op: SALEM SUMP 18
X-rays:
Water Pik/Wound Lavage: Yes ☐ No ☑ Water/Saline 2000ccX TURtubingX
Electrosurgical Unit(s) Type: VALLEYLAB BOVIE Serial # F2116546T Grounding site: (R) CALF POSTERIOR
Type: Serial # Grounding Site
~~Tniquet~~(s) Nitrogen ☐ Kidde ☐ Cuff: Single ☐ Double ☐
Checked by: _____ Location: _____ Pressure: _____ Up: _____ Down: _____
Checked by: _____ Location: _____ Pressure: _____ Up: _____ Down: _____
Irrigation Type: H2O Volume: 10000CC
Asepto/Splash Type: NACL Volume: 10000CC x12
Antibiotic/Other irrigation:
Drug & Concentration: BETADINE OINTMENT
Drug & Concentration:
Allergies: NONE KNOWN
Drains:
1 CHEST TUBE #36 TO 3 PLEURO/AC
2. 4.
F.S. Yes ☐ No ☑
Specimen(s): (A) GALLBLADDER
Implants & Serial # SEE CHARGE SHEET
Dressings: KERLIX - ABD'S - TAPE - 4X4
Deposition: ☐☐ R.R. ☐☐ D.S.U. ☐☐ I.C.U. #9 ☐☐ Nursing Unit ☐☐ Other
Wound Classification Clean ☑ Burns I ☐ Clean Contaminated ☐ Burns II ☐ Contaminated ☐ Burns III ☐ Dirty ☐ Non Surgical ☐
Remarks: PATIENT AWAKE x ORIENTED - DIFFICULTY BREATHING - CHEST TUBE (R) TO PLEURAVAC

Drugs On Field
Drug & Amount:
Drug & Amount:
Drug & Amount:
Drug & Amount:
Drug & Amount:
Cultures
1. NONE 3.
2. 4.

CALLED REPORT TO STICU @ 0350

Signature: Christi J. Anderson RN

cc: #JAMES H. DUKE, M.D., FAX # 7135007268

HERMANN HOSPITAL

J553E

NAME OF PATIENT: WALTER, KEVIN (C. WILFORD)
UNIT #: 96925490
SSN#:
DOB:
ROOM NUMBER:
DATE OF OPERATION: 11/07/98
CO-SURGEON:
ATTENDING PHYSICIAN: #JAMES H. DUKE M.D.

SURGEON: #JAMES H. DUKE M.D.

ASSISTANT SURGEON: ERIK A.K. BEYER, M.D.

PREOPERATIVE DIAGNOSIS: Multiple gunshot wounds of the chest and abdomen.

POSTOPERATIVE DIAGNOSES: Multiple gunshot wounds of the chest and abdomen; through-and-through gunshot wound of the central portion of the liver; right hemothorax.

PROCEDURES: Exploratory laparotomy; ligation of the common hepatic artery; cholecystectomy; coring the subcutaneous transverse lower abdominal gunshot wound.

ANESTHESIA: General endotracheal anesthesia.

FINDINGS: Major hemorrhagic gunshot wound on the dome of the liver near it's anatomical division between the right and left lobes; a left to right subcutaneous gunshot wound to an immensely thick lower abdominal pannus; morbid obesity.

HISTORY OF PRESENT ILLNESS: This 24-year-old male sustained multiple gunshot wounds on the evening of admission. He had evidence of a right hemothorax for which a chest tube was introduced and produced a substantial amount of blood in the early phases of it's drainage process. He also had an entrance wound in the lower abdomen that appeared to have a transverse trajectory from left to right. He was somewhat hypotensive in the Emergency Center and was taken to the operating room in an expeditious manner to attempt to control the hemorrhage that was causing these changes in his cardiovascular function.

PROCEDURE IN DETAIL: Under satisfactory general anesthesia, the patient was prepped from his chin to his knees. The entire operative field was draped out with sterile towels. These were held in place with staples. The remainder of the field was covered with sterile linen. An incision was made in the mid abdomen initially to explore the possibility of the lower abdominal gunshot wound entering the peritoneal cavity. During the process of making this incision, the transverse trajectory of the bullet was identified as being external to the peritoneal cavity. The midline was opened with electrocautery nonetheless, in the event that there had been an intraabdominal injury from the percussion blast of the projectile. There was an initial small amount of dark blood identified. The incision was enlarged to be able to further explore the abdomen. The more the wound was opened, the more blood seemed to be apparent. It then became clear that a significant amount of bright red blood was flowing from the upper quadrants. The incision was then enlarged to the xiphoid. All of this dissection was rather tedious because of the enormous pannus of obese tissue. It was necessary to taken down the falciform to gain enough exposure to be able to see the dome of the liver. When the dome of the liver was in clear view near the exact midline of the liver, a surprising column of bright red blood exuded from this wound. Attempting the Pringle maneuver, the blood flow ceased. It was apparent that a major hepatic artery injury had occurred. Because the patient was sufficiently unstable, the dissection of the common hepatic artery was expedited with no effort to identify the right or left branches. The hepatic artery was identified and ligated and the hemorrhage ceased. Because the ligation of the artery would probably render the gallbladder ischemic, focus was then directed towards the removal of this organ. This was accomplished by grasping the gallbladder with Kelly and Sarot clamps and placing it on tension. The peritoneal surface was then divided and the gallbladder dissected out of it's adherence to the hepatic bed. The cystic duct was identified and ligated. The cystic artery was also identified, doubly clamped and ligated with 2-0 chromic. When the confluence of the common duct and the cystic duct were identified, the cystic duct was clamped and divided. The cystic duct was then closed with two separate 2-0 chromic sutures. Although extensive attempts were made to identify the defect in the diaphragm through which the bullet passed, they were unsuccessful.

It was noted at this point that the blood flow from the chest tube had now ceased. It was assumed that the blood was flowing from the liver through the defect in the diaphragm into the chest and out the chest tube. The abdomen was irrigated with copious amounts of saline. The midline fascia was approximated with two #1 looped Maxon sutures. The subcutaneous tissue was approximated loosely with 2-0 chromic sutures. The gunshot wound on the inferior aspect of the left side of the abdomen was dressed by removing the site of entry where the tissue had been damaged. Although there was no evidence of an exit wound on the right side, a defect in the skin was created there for the purposes of drainage. The umbilicus was approximated with 2-0 nylon sutures.

The estimated blood loss was difficult to obtain. It was estimated that the combination of that which he lost in the chest tube and abdomen was approximately 2000 cc and that during the operative procedure, he lost another 1000 cc.

He appeared to tolerate this procedure satisfactorily. He was returned to the Shock Trauma Intensive Care Unit in critical condition.

DICTATED AND REVIEWED BY:

#JAMES H. DUKE M.D.
SURGEON

/92 J: 2694 CL:
D: 12/22/98 T: 12/28/98

DYNACARE HERMANN Laboratory Services

6411 Fannin
Houston, Texas 77030-1501
(713) 704-5227

Case No. S-98-18078
Surg. Date: 12/07/98
Date Received: 12/07/98

Ordering Location: HH
Client: HERMANN HOSPITAL
Ordering Physician: DUKE, JAMES H. (TRAUMA)
Copy to: DUKE, JAMES H. (TRAU

Account No.:	*969254909367 I*
Patient:	*WILFORD, KANE ***
	(00000)96925490
Physician:	*DUKE, JAMES H. (TRAUMA)*
Location:	*J553 00*
Date of Birth:	*05/14/1974 Age: 24 YRS Sex: M*

SURGICAL PATHOLOGY

CLINICAL INFORMATION

Preoperative diagnosis: Gunshot wound to abdomen, back, chest.

TISSUE/SOURCE DESCRIPTION

"Gallbladder"

GROSS DESCRIPTION

The specimen is received in formalin, in a container labeled with the patient's name (Kane Wilford), medical record number, and designated "gallbladder". The specimen consists of a tan-pink gallbladder that measures 7.1 x 2.1 x 0.9 cm. The surface of the gallbladder is tan-red and shiny. The gallbladder mucosa is hemorrhagic. The gallbladder contains approximately 10 cc of blood clot. Representative section is submitted in "A1".

M. Jalali, M.D./ddr 12/08/98 09:05

1 block, 1 H&E

MXJ:DDR

DIAGNOSIS

Gallbladder, cholecystectomy:
Acute hemorrhage.

Code 1
CPT 88304
12/09/98 13:05 yf

T57000, P11000, M37000

RAN:RAN:YMF By: R. ABOUL-NASR, M.D.
12/09/98 (Electronic Signature)

R. Charge Record

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

O.R. TIME 10:50 TO 11:25

12/16/98

Surgeon: MARVIN, ROBERT
Procedure: BRONJTUP BED W/ N-G TUBE PLACEMENT

Last Supply List Update: 09/04/98

Loc	Qty	Description	M	Code	Loc	Qty	Description	M	Code
EQUIPMENT									
IEQMT	1	PATIENT ACUITY LEVEL C		ACUITY C					
IEQMT	1	PATIENT ACUITY LEVEL C		ACUITY C					
IEQMT	1	CART, VIDEO #6600 14711		CARTSVID					
INSTRUMENTS SETS									
2INPT	1	FLEXIBLE/RIGID SCOPE		141503					
1 CORE									
3SCGR	1	SILICONE SPRAY		120025					
3SCGR	1	SET, 8 FR NASAL BILIARY DRAINAGE		140389					
3SCGR	1	SOLUTION, STERILE WATER FOR IRR 1000ML B		170073					
CENTRAL SUPPLY									
40SMH	1	DANNISTER-SUTTER 200CC		130052					

CONTINUATION OF OPERATING ROOM RECORD
MEDICAL RECORD COPY

5 of 13

ermann Hospital
R. Charge Record

[signature] 12/7/98 OR 21

96 92549 0 9367
WALTER ,KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

Surgeon: [illegible], JAMES
Procedure: LAPAEXPL LAPAROTOMY, EXPLORATORY

Last Supply List Update: 11/27/98

Loc	Qty	Description	?	Code
EQUIPMENT				
1EQMT	1	PATIENT ACUITY LEVEL C		ACUITY C
1EQMT	1	ELECTROSURGICAL/ARGON UNIT #... 12/1 19546T		ELECTROS
1EQMT	1	~~[illegible]~~ 0		~~[illegible]~~
1EQMT	1	~~[illegible]~~ 0		~~[illegible]~~
INSTRUMENTS SETS				
	1	LAP SOFT TISSUE-LAP A SET		TR313
1INST	1	LAP RETRACTORS-LAP B		TR314
CLEAN CORE	1	CHEST TUBE # 36		
3CCOP	1	~~[illegible]~~		~~[illegible]~~
3CCOR	1	PACK, GENERAL TRAUMA		140046
3CCOR	1	~~[illegible]~~		~~[illegible]~~
3CCOR	1	~~[illegible]~~		~~[illegible]~~
3CCOR	1	SOLUTION, STERILE WATER FOR IRR 1000ML B		170073
3CCOR	12	SOLUTION, SODIUM CHL .9% IRRI 1000ML BTL		170074
3CCOR	1	~~[illegible]~~		~~[illegible]~~
3CCOR	1	~~[illegible]~~		~~[illegible]~~
3CCOR	1	~~[illegible]~~		~~[illegible]~~
3CCOR	1	~~[illegible]~~		~~[illegible]~~
CENTRAL SUP	1	PLEUROVAC		
4CSMH	1	~~[illegible]~~		~~[illegible]~~
4CSMH	1	TUBE, SALEM SUMP 18FR W/ANTI REFLUX VLV		110865
4CSMH	1	~~[illegible]~~		~~[illegible]~~
4CSMH	1	TRAY, SKIN PREP WITH PVP IODOPHOR		120009
4CSMH	7	CANISTER, SUCTION 1000CC		150052
4CSMH	1	PAD, GROUNDING REM POLY II ADULT [illegible]		180017
4CSMH	1	DRESSING O.R. COVERLET [illegible]		190445
	1	VESSEL LOOP		

Loc	Qty	Description	?	Code
4CSMH	1	SKIN STAPLER STAINLESS STEEL 35 WIDE		182405
DRESSINGS	2	ABDS		
5DRES	1	DRESSING, GAUZE SPONGE 4X4 12-PLY STER		120011
5DRES	1	SPONGE, X-RAY DETECTABLE 4" X 8" 12-PLY #		120156
5DRES	1	LAP SPONGES 18" x 18" II		120161
5DRES	1	DRESSING, TEGADERM 4" X 4.75"		120163
5DRES	1	TAPE, MICROFOAM 4" (ELASTIC FOAM)		120217
SUTURE SECTION	1	KERLIX		
7SUTR	2	SUTURE, 3-0 CHROMIC GUT T-5 [illegible]		121127
7SUTR	1	~~[illegible]~~		~~[illegible]~~
7SUTR	1	SUTURE, 2-0 SILK BLK BR 30" (75CM)		121280
7SUTR	1	~~[illegible]~~		~~[illegible]~~
7SUTR	1	SUTURE, 3-0 SILK BLK SF 30"75CM A622H		121701
7SUTR	1	~~[illegible]~~		~~[illegible]~~
7SUTR	1	SUTURE, 2-0 SILK 30" T-5 BLK PER 1120-51		120783
7SUTR	1	~~[illegible]~~		~~[illegible]~~

1 SILK 3/0 1217-42 I
1 SILK 2/0 COR-D I
2 PDS II I Z880G II
2 DERMALON 3/0 1627-41 II

CONTINUATION OF OPERATING ROOM RECORD
MEDICAL RECORD COPY

ERMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

NAME:
ACCT:

12-7-98
to
12-8-98

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	7-3	3-11	11-7
12-7-98	RS	LR 140 cc/hr.	1300 [illegible]	19 [illegible]	02[00] [illegible]
12-7-98	Rs	Cefoxitin 2gm IVPB Q6° x 2 days	09 [illegible]	15 [illegible] 21 [illegible]	03 [illegible]
12-7-98	Rs	Carafate 1 gm PO/NGT Q 6°	09 [illegible]	15 [illegible] 21 [illegible]	03 [illegible]
12/7		Tylenol 650 mg PR/elixir Q4° prn T>38.5	1400 [illegible]	2130 [illegible]	02[30] [illegible]
12/7		Ca Gluconate 2gm IV over 1 hr	0830 [illegible]		
12-7-98	Rs	MSO4 2-10 mg IV Q 2-4° PRN	0820 [illegible] (4mg) 1000 [illegible] (4mg) 1400 [illegible] (4mg)	1830 [illegible] (4mg) 2100 [illegible] 23[00] [illegible] (4mg)	03[illegible] [illegible] 0434 [illegible]
12-7-98	Rs	Ativan 2-4 mg IV Q 2-4° PRN	0825 [illegible] (2mg)		

INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
		Rs	[illegible signature]	[illegible]	[illegible signature]
		[illegible]	[illegible signature]	[illegible]	[illegible signature]

HERMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

NAME:
ACCT:

96 92549 0 9367
WALTER ,KEVIN
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	7-3	3-11	11-7
12/6/98		LR @ 140cc/Hr IV			0510 R
12/6/98		Cefoxitin 2 gm IV x2 q6°	~~0900~~	~~1500~~	
12/6/98		Carafate 1 gm PO/NGT q6°	~~1000~~	~~1600~~ ~~2200~~	0400
12-6	RS	MSO4 8 mg IV			0545 RS
12-6	RS	Ativan 4 mg IV			0545 RS

INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
				RS	[signature]

HERMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

NAME: WILFORD, KANE **
ACCT: 969254909367
AGE: 24yr
I[illegible]: DUKE, JAMES H. (T
SERVICE: TRAUMA
ALLERGIES: UNKNOWN PATIENT ALLERGIES

STIC STIC-09
SEX: M
HGT: 180.34 cm
WT: 161.98 kg
BSA: 2.70 M2

GENERATED: 12-07-98 11:16pm
FOR PERIOD: 12-08-98 07:00
THROUGH: 12-09-98 06:59
ADMITTED: 12-07-98 12:22am

DIAGNOSIS: WOUND OPEN/UNSPEC COMPL

PAGE: 1 OF 1

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
12-07 07 12-09 06		CEFOXITIN 2GM BASE SOLUTION 50ML FREQ: Q6 INFUSE @: 100 ML/HR KEEP REFRIGERATED FOR 2 DAYS (401628)	07 12 15 0900 JRW	** ORDER ENDS @ 12-09-98 06 * 17 2100 RB	01 05 00 RB
12-07 08 01-06 07	MT	LACTATED RINGERS 1000ML FREQ: Q8H INFUSE @: 140 ML/HR (401627)	08 JRW	16 1500 JRW	24 RB
12-07 10 01-06 09	RB	SUCRALFATE 1GM SUSP PO Q6H POTENTIAL FOR DRUG-DRUG INTER- ACTIONS SIMULTANEOUS ADMIN. REFER TO POSTED RECOMENDATIONS PO/NGT (401629)	10 JRW	16 JRW 22 RB	04 RB
12-7	RB	500 cc NS IV now x2			0530 RB 0300 RB
					0230
12-7-98		Ativan 2mg-4mg IV q 2-4 hr pr nausea		1535) 2mg JRW 2000 (2mg) RB	22 RB (2) 0000 RB (2) 0300 RB (2)
12-7-98		MSO4 2-10mg IV q 2-4 prn pain	0900) 4mg JRW 1120) 4mg JRW 1215) 4mg JRW 1430) 5mg JRW	1630) 5mg JRW 1810) 4mg JRW 2000 5mg RB	22 RB 5) 0100 RB 5) 0300 RB 5)
		======== P R N O R D E R S ========			
12-07 14 01-06 13	RB	ACETAMINOPHEN 650MG SUPP PR Q4HPRN FOR TEMP > 38.5 C (404496)			
12-07 14 01 3	RB	ACETAMINOPHEN 650MG LIQ PO Q4HPRN TEMP > 38.5 C (404491)	0925) JRW	1530) JRW	

ALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
RB	[illegible]	JRW	Jennifer R. Wilson RN	RD	R. Butcher RN

MANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

E: WILFORD, KANE **
T: 969254909367
[illegible]UKE, JAMES H. (T
ILE: TRAUMA
ERGIES: UNKNOWN PATIENT ALLERGIES

STIC STIC-09
EX: M
GHT: 180.34 cm
T: 161.98 kg
BSA:2.70 M2

GENERATED: 12-08-98 11:36pm
FOR PERIOD: 12-09-98 07:00
THROUGH: 12-10-98 06:59
ADMITTED: 12-07-98 12:22am

GNOSIS: WOUND OPEN/UNSPEC COMPL

START STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
-07 08 -06 07	RB	LACTATED RINGERS 1000ML (401627) FREQ: Q8H INFUSE @: 140 ML/HR	08 13 PM	16 19 N	24 RB
-07 10 -06 09	RB	SUCRALFATE IGM SUSP PO Q6H (401629) POTENTIAL FOR DRUG-DRUG INTER- ACTIONS SIMULTANEOUS ADMIN. REFER TO POSTED RECOMENDATIONS PO/NGT	10 P	16 N 22 RB	04 RB
9.	W	Impact FS 15cc/hr DNT Advance Per Protocol			~~03 RB~~
10	RB	Reglan 10mg IV			03 RB
7/98	RB	Ativan 2mg - 4mg IVq 2-4hr		22 RB (2mg)	22 RB (2mg)
7/98	RB	MSO4 2-10 IV q 2-4 prn	08 SN 1305 (4mg) DM 16 N	19 N 22 RB (5mg)	24 (5mg) RB
		======== P R N O R D E R S ========			
-07 14 -06 13	RB	ACETAMINOPHEN 650MG LIQ PO Q4HPRN (404491) TEMP > 38.5 C	11 N	15 N	24 RB
-07 14	RB	ACETAMINOPHEN 650MG SUPP PR Q4HPRN (404496) FOR TEMP > 38.5 C			

ALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
	R. Brutcher RN			JM	SM LCDRN

ERMANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

AME: WILFORD, KANE ** | SIMU SIMU-06 | GENERATED: 12-23-98 11:05pm
CCT: 969254909367 | SEX: M | FOR PERIOD: 12-24-98 07:00
AGE: 24yr | HGT: 180.34 cm | THROUGH: 12-25-98 06:59
D[illegible]: DUKE, JAMES H. (T | WT: 130.18 kg | ADMITTED: 12-07-98 12:22am
S[illegible]E: TRAUMA | BSA:2.46 M2
ALLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
DIAGNOSIS: WOUND OPEN/UNSPEC COMPL

PAGE: 1 OF 2

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
12-16 16 / 12-30 15	OD	GENTAMICIN 440MG (436085) NACL 0.9% 100ML FREQ: Q8H INFUSE @: 219.64 ML/HR KEEP REFRIGERATED	08 Pg	16 Pg	24 PJ
12-22 18 / 01-21 17	OD	IMPACT OBAG LIQ TF Q3 (459781) 105CC/HR READY TO HANG FULL STRENGTH 11c/1 D'd see Vola	10	~~16~~ 1500 B	02
12-18 21 / 12-30 20	OD	LEVOFLOXACIN 500MG/100ML D5W 500MG (447630) BASE SOLUTION 100ML FREQ: Q24 INFUSE @: 100 ML/HR PROTECT FROM LIGHT DO NOT REFRIGERATE		21 OD	
12-23 16 / 01-22 15	OD	NACL 0.9% 1000ML (463721) FREQ: Q24 INFUSE @: 20 ML/HR FLOORSTOCK ITEM		(16)	0500 OD
[illegible] 19 / 01-22 18	OD	OMEPRAZOLE ORAL SUSPENSION 20MG SUSP PO QD (437471) SHAKE WELL KEEP REFRIGERATED	09 Pg		
12-22 08 / 12-30 07	OD	VANCOMYCIN 2000MG (456775) DEXTROSE 5% IN WATER 250ML FREQ: Q8H INFUSE @: 125 ML/HR KEEP REFRIGERATED	08 Pg	16 Pg	24 PJ
12/24	Pg	Colace 100mg q12° LHT	09 Pg	2100 100mg stool	
12/24	LS	Promote at 85 ml		2210 OD	
12/23	LS	dulcolax supp PRN QD. P.R.		2100 10mg stool	

INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
	Geralda Wallace		Pat Bryant		

IR_-LI_E
ERMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

NAME: WILFORD, KANE ** SIMU SIMU-06 GENERATED: 12-24-98 11:20pm
ACCT: 969254909367 SEX: M FOR PERIOD: 12-25-98 07:00
AGE: 34yr HGT: 180.34 cm THROUGH: 12-26-98 06:59
DR: DUKE, JAMES H. (T WT: 136.07 kg ADMITTED: 12-07-98 12:22am
SERVICE: TRAUMA BSA:2.51 M2
ALLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
DIAGNOSIS: WOUND OPEN/UNSPEC COMPL PAGE: 1 OF 2

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
12-16 16 / 12-30 15	GM	GENTAMICIN 440MG (436085) NACL 0.9% 100ML FREQ: Q8H INFUSE @: 219.64 ML/HR KEEP REFRIGERATED	08 PB	16	24
12-10 21 / 12-30 20	GM	LEVOFLOXACIN 500MG/100ML D5W 500MG (447630) BASE SOLUTION 100ML FREQ: Q24 INFUSE @: 100 ML/HR PROTECT FROM LIGHT DO NOT REFRIGERATE		21	
12-23 16 / 01-22 15	GM	NACL 0.9% 1000ML (463721) FREQ: Q24 INFUSE @: 20 ML/HR FLOORSTOCK ITEM		16	
12-16 19 / 01-22 18	GM	OMEPRAZOLE ORAL SUSPENSION 20MG SUSP PO QD (437471) SHAKE WELL KEEP REFRIGERATED	09 PB		
12-24 18 / 01-23 17	GM	PROMOTE OBAG LIQ TF Q8 (468764) FULL STRENGTH 85CC/HR READY TO HANG	10 900 PB	18	02
12-22 08 / 12-30 07	GM	VANCOMYCIN 2000MG (456775) DEXTROSE 5% IN WATER 250ML FREQ: Q8H INFUSE @: 125 ML/HR KEEP REFRIGERATED	08 PB	16	24
12/23	GM	Colace 100mg q12° DHT	0900	2100	
12/23	GM	dulcolax supp QD / PRN PR.			

INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
GJ	Geraldine A. Wall			VA	V. Abalu RN

RMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

ME:
CT: WILFORD, KANE **
969254909367
E: 24yr
CTOR: DUKE, JAMES H. (T
RVICE: TRAUMA
LERGIES: UNKNOWN PATIENT ALLERGIES

IC STIC-09
EX: M
GT: 180.34 cm
T: 161.98 kg
BSA:2.70 M2

GENERATED: 12-09-98 11:03pm
FOR PERIOD: 12-10-98 07:00
THROUGH: 12-11-98 06:59
ADMITTED: 12-07-98 12:22am

AGNOSIS: WOUND OPEN/UNSPEC COMPL

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY		07:00-15:00	15:01-23:00	23:01-0
12-07 08 / 11-06 07	RB	LACTATED RINGERS 1000ML FREQ: [illegible] INFUSE @: 140 ML/HR	(401627)	08	16	24
12-07 10 / 11-06 09	RB	SUCRALFATE 1GM SUSP PO Q6H POTENTIAL FOR DRUG-DRUG INTER- ACTIONS SIMULTANEOUS ADMIN. REFER TO POSTED RECOMENDATIONS PO/NGT	(401629)	10 W	16 W 22 RB	04 RB
		D5 1/2 NS + 20 KCl @ 125 cc/hr IV		10 W	17 W	24 RB
	RB	~~Impact FS 15 cc/hr~~ Phenergan 12.5-25mg PRN ~~advance for protocol~~				
		IB-profen 400mg Q4°. PO.			16 W 20 RB	24 RB 04 RB
		Promote fs @ 10 cc/hr IV ======== P R N O R D E R S ======== D/T			18 W	
12-07 14 / 11-06 13	RB	ACETAMINOPHEN 650MG LIQ PO Q4HPRN TEMP > 38.5 C	(404491)	10 W 12 W	21 RB	
12-07 14 / 11-06 13	RB	ACETAMINOPHEN 650MG SUPP PR Q4HPRN FOR TEMP > 38.5 C	(404496)			
12-09 11 / 12-16 10	RB	LORAZEPAM 2MG INJ IV Q2-4HPRN (AVOID ALCOHOL) GIVE 2MG TO 4MG PRN	(411747)	09 W 1130 W	15 W 1430 (2mg)	24 RB 04 RB (2)
12-[illegible] / 12-16 10	RB	MORPHINE 2MG INJ IV Q2-~~4~~10HPRN GIVE 2MG TO 10MG PRN	(411782)	09 W 1130 W	15 W 1930 RB (5mg)	24 RB (5mg) 04 RB (2)

ALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
B	R. Butcher RN	W	[illegible] MD		

RMANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

ME:
CT:

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY			
		Reglan 10 mg IV now			0300RT

ALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
B	R. Bustacher RN				

IERMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

IAME: WILFORD, KANE **
CCT: 969254909367
AGE: 24YR
: DUKE, JAMES H. (T
SE: TRAUMA
ALLERGIES: UNKNOWN PATIENT ALLERGIES

STIC STIC-09
EX: M
GHT: 180.34 cm
T: 161.98 kg
BSA:2.70 M2

GENERATED: 12-10-98 11:02pm
FOR PERIOD: 12-11-98 07:00
THROUGH: 12-12-98 06:59
ADMITTED: 12-07-98 12:22am

DIAGNOSIS: WOUND OPEN/UNSPEC COMPL

PAGE: 2 OF 2

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY		07:00-15:00	15:01-23:00	23:01-0
12/10	RB	Phenergen 12.5-25mg PRN		13/5 CL		
		======== P R N O R D E R S ========				
12-07 14 / 01-06 13	RB	ACETAMINOPHEN 650MG LIQ PO Q4HPRN TEMP > 38.5 C	(404491)	09/30 CL 1330 CL		
12-07 14 / 01-06 13	RB	ACETAMINOPHEN 650MG SUPP PR Q4HPRN FOR TEMP > 38.5 C	(404496)			
12-10 12 / 01-09 11	RB	IBUPROFEN 400MG SUSP PO ~~Q4HPRN~~ <Take with Food> ALTERNATE WITH TYLENOL	(416463)	08/09 CL 12/1300 CL	16 20	24 04
12-09 11 / 12-16 10	RB	LORAZEPAM 2MG INJ IV Q2-4HPRN <AVOID ALCOHOL> GIVE 2MG TO 4MG PRN	(411747)			
12-09 11 / 5 10	RB	MORPHINE 2MG INJ IV Q2-~~4~~HPRN GIVE 2MG TO 10MG PRN 10	(411782)	11/RO. CL		

INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
RB	R. Brutsche RN	GW	Gwen Watson RN		

RMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

ME: WILFORD, KANE **
CT: 969254909367
IC DUKE, JAMES H. (T
RV...E: TRAUMA
LERGIES: UNKNOWN PATIENT ALLERGIES

STIC STIC-09
SEX: M
GHT: 180.34 cm
HT: 161.98 kg
BSA:2.70 M2

GENERATED: 12-10-98 11:02pm
FOR PERIOD: 12-11-98 07:00
THROUGH: 12-12-98 06:59
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AGNOSIS: WOUND OPEN/UNSPEC COMPL

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
~~2-10~~ 16)1-09 15	RB	DEXTROSE 5%-NACL 0.45%-KCL 20MEQ 1000ML (416217) FREQ: Q8H INFUSE @: 125 ML/HR	08 11 cc	16	24
12-10 18)1-09 17	RB	~~10~~ PROMOTE OBAG LIQ TF Q8 (417423) ~~30~~CC/HR READY TO HANG FULL STRENGTH	10 Held	18	02
12-07 10)1-06 09	RB	SUCRALFATE 1GM SUSP PO Q6H (401629) POTENTIAL FOR DRUG-DRUG INTER- ACTIONS SIMULTANEOUS ADMIN. REFER TO POSTED RECOMENDATIONS PO/NGT	10 cc	~~16~~ cc 22	04

ALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
5	R. Burtchen RN	CW	Gwen Watson	CC	Cynthia Little RN

MANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

IE:
T:

96 92549 0 9367
WILFORD ,KANE **
BM Age 24y DOB 05/04/74
Visit/Admit Dt 12/07/98

12/11/98

ART / TOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY			
12/98	PM	D5 1/2 NS +20 meq KCL @ 125 c/hr			
12/98	PM	tylenol 650 MG q 4-6° prn T>101.5 + HA PO/PR			
12/98	PM	Ativan 2MG q 2-4° prn agitation IV			0205 a
12/98	PM	MSO4 2MG q 2-4° prn agitation IV			0205 c
12/98	PM	Vicodin 1 + 1/2 tabs q 3° prn pain		2150	
12/98	PM	Phenergan 12.5 MG q 4-6° prn N/V IV			
12/98	PM	Benadryl 25MG q hs prn insomnia IV		2150	

LS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
2	Chris Okafor	PM	Pat Bryant		

RMANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

NAME: WILFORD, KANE **
ID: 969254909367
[illegible]
[illegible] DUKE, JAMES H. (T
ADV. DIR: TRAUMA
ALLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
DIAGNOSIS: WOUND OPEN/UNSPEC COMPL

[illegible]MU S1MU-06
SEX: M
HT: 180.34 cm
WT: 161.98 kg
BSA: 2.70 M2

GENERATED: 12-12-98 12:09am
FOR PERIOD: 12-12-98 07:00
THROUGH: 12-13-98 06:59
ADMITTED: 12-07-98 12:22am

PAGE: 1 OF 1

START STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
12-11 24 12-10 23	CW	DEXTROSE 5%-NACL 0.45%-KCL 20MEQ 1000ML (422235) FREQ: 08H INFUSE @: 125 ML/HR	~~00~~ 1200 RJ	~~16~~	(24) infusing
12/12	RB	Rasiq 10 mg IV now	0807 RB		
12/12	RB	Restoril 15-30mg PO PRN insomnia		2100	
		======== P R N O R D E R S ========			
12-10 23	CW	ACETAMINOPHEN 650MG TAB PO Q4-6HPRN (422237) TEMP>101			
12-11 23 12-10 22	CW	ACETAMINOPHEN 650MG SUPP PR Q4-6HPRN (422236) TEMP>101 SEE PR ORDER			
12-11 24 12-10 23	CW	DIPHENHYDRAMINE 25MG INJ IV PRNHS (422234) FOR INSOMNIA			DC
12-11 23 12-10 22	CW	HYDROCODONE W/APAP 5MG/500MG TTAB TAB PO Q3HPRN (422239) 1 - 2 TABLETS AS NEEDED			
12-11 23 12-10 22	CW	MORPHINE 2MG INJ IV Q2-4HPRN (422238) AGITATION	1130 (2) RJ	2045 JS	2315 JS
12-11 23	CW	PROMETHAZINE 12.500MG INJ IV Q4-6HPRN (422240) FOR NAUSEA AND VOMITING	1430 RJ	22 JS	02 JS

INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
RB	[illegible]	RJ	Pat Bryant	JS	[illegible]
	RENEE' JARVIS, RN				

MANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

IE:
T: **96 92549 0 9367**
WILFORD , KANE **
BM Age 24y DOB 05/14/74
Visit/Admit Dt 12/07/98

12/12/98

ART TOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY			
12	RJ	Lasix 10 mg IV now	0930 RJ		
		MSO4 10mg IV	1400 RJ		
	US	MSO4 10mg IV			02 US 03/15 US
	US	Ativan 4mg IV			02 US 03/15 US
12/13		Ativan 2mg IV Q2-4° prn Agitation	15 RJ	1830 RJ	

ALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
J	RENEE JARVIS, RN	RJ	Pat Bryant	PB	
				US	

IRSELITE

ERMANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

AME: WILFORD, KANE **
CCT: 969254909367
GF yr
OL DUKE, JAMES H. (T
ERVICE: TRAUMA
LLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
IAGNOSIS: WOUND OPEN/UNSPEC COMPL

STIC STIC-19
EX: M
T: 180.34 cm
T: 130.18 kg
BSA:2.46 M2

GENERATED: 12-12-98 11:11pm
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PAGE: 1 OF 2

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
12-12 16 / 01-11 15	JS	~~DEXTROSE 5% NACL 0.45% KCL 20MEQ~~ 1000ML (423064) FREQ: Q8H INFUSE @: 125 ML/HR Δ TO NS	~~06~~ 0730 RJ	16 RJ	24 JS
12-13-98	RJ	SUCRALFATE 1 gm NGT Q6°	10 RJ	16 RJ	22 JS 04 JS
12-13-98	RJ	IBUPROFEN 200mg ELIXIR NGT QID PRN	1130 RJ		
12-13-98	RJ	ESMOLOL 30mg IV NOW MAY RPT X1	1040 RJ 1045 RJ		
12-13-98	RJ	NS 1L IV BOLUS X 1 NOW	1430 RJ		

TIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
JS	[illegible]	RJ	RENEE' JARVIS, RN		

ERMANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

AME: WILFORD, KANE **
CCT: 969254909367
IC [illegible]yr
IO [illegible] DUKE, JAMES H. (T
ERVICE: TRAUMA
LLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
IAGNOSIS: WOUND OPEN/UNSPEC COMPL

ETIC STIC-19
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START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY		07:00-15:00	15:01-23:00	23:01-0
12-13-98	RJ	MSO4 10mg IV RPT X 1 AGAIN @ 1100		1030 RJ 1035 RJ 1100 RJ		
12-13-98	RJ	ROCURONIUM 50mg IV X 1 NOW		1035 RJ		
12-13-98	RJ	ATIVAN 4mg IV X 1 NOW ======== P R N O R D E R S ========		1035 RJ		
12-12 10 01-11 09	JS	ACETAMINOPHEN 650MG SUPP PR Q4HPRN TEMP>101 SEE PR ORDER	(422840) D/C			
12-12 10 01-11 09	JS	ACETAMINOPHEN 650MG TAB PO Q4HPRN TEMP>101 NGT	(422839) D/C	8 RJ		
12-11 23 12-19 22	JS	HYDROCODONE W/APAP 5MG/500MG 1TAB TAB PO Q3HPRN 1 - 2 TABLETS AS NEEDED	(422239)			
12-12 10 12-19 09	JS	LORAZEPAM 2MG INJ IV Q2-4HPRN FOR AGITATION (AVOID ALCOHOL)	(422846)	1030 RJ	1930 JS	
12-11 23 12-19 22	JS	MORPHINE 2MG INJ IV Q2-4HPRN AGITATION	(422238)	1030 RJ	1930 JS	
12-12 11 01-11 10	JS	PROMETHAZINE 12.500MG INJ IV Q4-6HPRN FOR NAUSEA AND VOMITING	(423066)	1030 RJ		
12-12 11 12 [illegible] 10	JS	TEMAZEPAM 15MG CAP PO PRN 15-30MG FOR INSOMNIA	(423065)			

ITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
JS	[illegible]	RJ	RENEE' JARVIS, RN		

RMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

ME: WILFORD, KANE **
DT: 969254909367
E: 24yr
C DUKE, JAMES H. (T
R TRAUMA
LERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
AGNOSIS: WOUND OPEN/UNSPEC COMPL

STIC STIC-19
EX: M
GHT: 180.34 cm
T: 130.18 kg
BSA:2.46 M2

GENERATED: 12-13-98 10:56pm
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ADMITTED: 12-07-98 12:22am

START STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
12-12 16 1-11 15	US	~~DEXTROSE 5% NACL 0.45%-KCL 20MEQ 1000ML FREQ: Q8H .REUSE #: 125 ML/HR~~ (423064) D/d to NS	~~06~~ 1330 RJ	~~16~~	24
12-13 10 1-12 09	US	SUCRALFATE 1GM SUSP NG Q6H (424596) POTENTIAL FOR DRUG-DRUG INTER-ACTIONS SIMULTANEOUS ADMIN. REFER TO POSTED RECOMENDATIONS	10 RJ	~~16~~ 22 RJ JM	04 JM
14-98	RJ	ZOFRAN 8mg IV MAY REPEAT Q15" IF Ø RELIEF TO MAX OF 32 mg Q6° PRN N/V			
~~14-98~~	~~RJ~~	~~ATIVAN~~ RJ			
~~14-98~~	~~RJ~~				
-14-98	RJ	THORAZINE 25mg IV Q6° PRN HICCUPS			
4-98	JM	Cefipime 1 gram IV Q8°			24 JM
1498	JM	Flagyl 500mg IV Q6°			24 JM 06 JM

ALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
US	Jenny Stanaland RN	RJ	RENEE' JARVIS, RN	JM	Jennifer Moen, RN

HERMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

NAME: WILFORD, KANE **
ACCT: 96925490367
AGE: 24yr
DR: DUKE, JAMES H. (T
CE: TRAUMA
ALLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
DIAGNOSIS: WOUND OPEN/UNSPEC COMPL

STIC STIC-19
EX: M
GHT: 180.34 cm
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GENERATED: 12-13-98 10:56pm
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START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY		07:00-15:00	15:01-23:00	23:01-0
		======== P R N O R D E R S ========				
A 23 / 12-19 22	JS	HYDROCODONE W/APAP 5MG/500MG 1TAB TAB PO Q3HPRN 1 - 2 TABLETS AS NEEDED	(422239)			
12-13 12 / 01-12 11	JS	IBUPROFEN 200MG SUSP NG QIDPRN (Take with Food)	(425380)		1530 RJ 2430 JM	
12-12 10 / 12-19 09	JS	LORAZEPAM ~~2MG IVP IV Q2-4HPRN~~ 2-4 mg IV Q2-4° PRN FOR AGITATION (AVOID ALCOHOL)	(422846)	0930 RJ (2) 1200 RJ (4)	1600 RJ (4) 2130 (4) JM	2430 (4) JM
12-11 23 / 12-19 22	JS	MORPHINE ~~2MG IVP IV Q2-4HPRN~~ 2-10 mg IV Q2-4° PRN AGITATION	(422238)	0930 RJ (2) 1200 (12) RJ	1600 RJ (10) 2130 (5) JM	2430 (10) JM 0400 (5) JM
12-12 11 / 01-11 10	JS	PROMETHAZINE 12.500MG INJ IV Q4-6HPRN FOR NAUSEA AND VOMITING	(423066)	1202 RJ		
12-12 11 / 9 10	JS	TEMAZEPAM 15MG CAP PO PRN 15-30MG FOR INSOMNIA	(423065)			

INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
JS	[illegible] STRICKLAND RN	RJ	RENEE' JARVIS, RN	JM	Jennifer Moen, RN

ERMANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

AME: WILFORD, KANE **
OCT: 969254909367
GE: 24yr
O DUKE, JAMES H. (T
E: TRAUMA
LLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
IAGNOSIS: WOUND OPEN/UNSPEC COMPL

IC STIC-19
EX: M
T: 180.34 cm
: 130.18 kg
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GENERATED: 12-14-98 10:59pm
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ADMITTED: 12-07-98 12:22am

12/31

PAGE: 1 OF 2

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
12-12 16 / 01-11 15		DEXTROSE 5%-NACL 0.45%-KCL 20MEQ 1000ML (423084) FREQ: Q8H INFUSE @: 125 ML/HR	08	16	24
12-13 10 / 01-12 09	JM	SUCRALFATE 1GM SUSP NG Q6H (424596) POTENTIAL FOR DRUG-DRUG INTER-ACTIONS SIMULTANEOUS ADMIN. REFER TO POSTED RECOMENDATIONS	10 PR	16 22	04
2-14	JM	NS @ 125cc/hr IV			02
2-14	JM	Cefipime 1gram IV Q8°	08 PR	16 PR	24
2-14	JM	Flagyl 500mg IV Q6° PR DCd 11:15Am	10	10 22	04
2/15	P.	Normal Saline 1 Liter Bolus	730 PR		
2/15/98	P.	Gentamycin 80mg (one time dose iv) Gent levels 2-4' and 8' Post Dose	1330 PR		
2/15/98	P	Ancef 2g IV For Hepatic Drainage Procedure Ativan 1mg IV		1100 PR	
2/15/98	P.	~~Ancef 1gm IV For Drainage Procedure~~ (Placed on PRN Sheet)		~~1147 PR~~	

TIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
JM	Jennifer Mercer	P	Paul Robillard		

ERMANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

AME: WILFORD, KANE **
CCT: 969254909367
AGE: 24yr
D R: DUKE, JAMES H. (T
S E: TRAUMA
ALLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
DIAGNOSIS: WOUND OPEN/UNSPEC COMPL

STIC STIC-19
SEX: M
GT: 180.34 cm
T: 130.18 kg
BSA: 2.46 M2

GENERATED: 12-14-98 10:59pm
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START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY		07:00-15:00	15:01-23:00	23:01-0
		~~[illegible]~~				
		======== P R N O R D E R S ========				
12-14 15 / 01-13 14	JM	CHLORPROMAZINE 25MG INJ IV Q6HPRN (AVOID ALCOHOL)	(429635)	1230 PR		
12-11 23 / 12-19 22	JM	HYDROCODONE W/APAP 5MG/500MG 1TAB TAB PO Q3HPRN 1 - 2 TABLETS AS NEEDED	(422239)			
12 12 / 01-12 11	JM	IBUPROFEN 200MG SUSP NG QIDPRN (Take with Food)	(425380)		2018	
12-12 10 / 12-21 09	JM	LORAZEPAM 2MG INJ IV Q2-4HPRN FOR AGITATION (AVOID ALCOHOL MAY GIVE 2-4MG	(422846)	1430 PR 2mg	1630 PR 1830 PR 4mg	0530 4mg
12-14 13 / 12-21 12	JM	MORPHINE 2MG INJ IV Q2-4HPRN MAY GIVE 2-10MG	(429029)	810 PR 4mg 910 PR 4mg 1230 PR 4mg 1430 PR 4mg	1630 PR 10mg 1830 PR 10mg	0530 4mg
12-14 14 / 01-13 13	JM	ONDANSETRON 8MG INJ IV Q6HPRN MAY REPEAT Q15MIN IF NO RESULTS TO A MAX OF 32MG	(429016)			
12-12 11 / 01-11 10	JM	PROMETHAZINE 12.500MG INJ IV Q4-6HPRN FOR NAUSEA AND VOMITING	(423066)			
12-12 11	JM	TEMAZEPAM 15MG CAP PO PRN 15-30MG FOR INSOMNIA	(423065)			

S	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
	Jennifer Brenner RN	P.	[illegible]		[illegible]

ERMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

NAME: WILFORD, KANE **
ACCT: 969254909367
AGE: 24yr
[redacted]: DUKE, JAMES H. (T
[redacted]E: TRAUMA
ALLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
DIAGNOSIS: WOUND OPEN/UNSPEC COMPL

STIC STIC-19
SEX: M
HGT: 180.34 cm
WT: 130.18 kg
BSA: 2.46 M2

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ADMITTED: 12-07-98 12:22am

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
12-14 24 12-21 23	✓ KS	CEFEPIME 1GM NACL 0.9% 50ML (430582) FREQ: Q8H INFUSE @: 100 ML/HR KEEP REFRIGERATED PROTECT FROM LIGHT	08 RC	16	24 KS
12-15 08 01-14 07	✓ KS	NACL 0.9% 1000ML (431270) FREQ: Q8H INFUSE @: 125 ML/HR	08 RC	16 1500	24 KS 0330 KS
12-13 10 01-12 09	✓ KS	SUCRALFATE 1GM SUSP NG Q6H (424596) POTENTIAL FOR DRUG-DRUG INTER- ACTIONS SIMULTANEOUS ADMIN. REFER TO POSTED RECOMENDATIONS DC'D	10	16 22	04
-16-98	RC ✓	~~MgSO4 .15mEq/Kg in 250 IV over 24° IV~~ ~~X 1~~			
	✓	MgSO4 0.5 mEq/Kg in 250 NS IV over 24° x 3 days	1230 # 1 Day		
	✓	Gentamycin 440 mg q 8° Draw P+T c 3rd dose		1600 #1	24 #2 KS
	✓	omeprazole 20mg PO Qd via NGT only		21 KS	
		Promote @ 15 c/hr		23 KS	
12/16		100 mg Pamerol 4 mg Vecuronium 100 mg Rocuronium	1115		

INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
KS	G. Scott RN	RC	Robert Cranwell RN		Rachel Jones

ERMANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

AME: WILFORD, KANE **
CCT: 969254909367
AGE: 24yr
DUKE, JAMES H. (T
SE: TRAUMA
ALLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
DIAGNOSIS: WOUND OPEN/UNSPEC COMPL

TIC STIC-19
SEX: M
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START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
		======== P R N ORDERS ========			
12-14 15 / 01-13 14	GS	CHLORPROMAZINE 25MG INJ IM Q6HPRN (AVOID ALCOHOL) (429635)			
12-11 23 / 12-19 22	GS	HYDROCODONE W/APAP 5MG/500MG 1TAB TAB PO Q3HPRN 1 - 2 TABLETS AS NEEDED (422239)			
12 12 / 01-12 11	GS	IBUPROFEN 200MG SUSP NG QIDPRN (Take with Food) (425380)	1000	2130 GS	
12-12 10 / 12-21 09	GS	LORAZEPAM 2MG INJ IV Q2-4HPRN FOR AGITATION (AVOID ALCOHOL) MAY GIVE 2-4MG (422846)	0915 2mg 1230 2mg	1530 2mg 1815 2mg 2130 GS (4mg)	0620 (2mg) GS
12-14 13 / 12-21 12	GS	MORPHINE 2MG INJ IV Q2-4HPRN MAY GIVE 2-10MG (429029)	0730 4mg 0915 5mg 1230 10mg	1530 10mg 1815 5mg 2130 (10mg) GS	0620 (4mg) GS
12-14 14 / 01-13 13	GS	ONDANSETRON 8MG INJ IV Q6HPRN MAY REPEAT Q15MIN IF NO RESULTS TO A MAX OF 32MG (429016)			
12-12 11 / 01-11 10	GS	PROMETHAZINE 12.500MG INJ IV Q4-6HPRN FOR NAUSEA AND VOMITING (423066)			
12-12 11 / 2	GS	TEMAZEPAM 15MG CAP PO PRN 15-30MG FOR INSOMNIA (423065)			

INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
GS	G. Scottsen	RL	Robert [illegible]	AM	Amy [illegible]

RMANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

ME: WILFORD, KANE **
CT: 969254909367
E: [illegible]
C [illegible] DUKE, JAMES H. (T
RV...: TRAUMA
LERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
AGNOSIS: WOUND OPEN/UNSPEC COMPL

STIC STIC-19
SEX: M
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THROUGH: 12-18-98 06:59
ADMITTED: 12-07-98 12:22am

PAGE: 1 OF 2

START STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
12-14 24 12-21 23	GS	CEFEPIME 1GM (430582) NACL 0.9% 50ML FREQ: Q8H INFUSE @: 100 ML/HR KEEP REFRIGERATED PROTECT FROM LIGHT	08 MJ	16	24 GS
12-16 16 12-23 15	GS	GENTAMICIN 440MG (436085) NACL 0.9% 100ML FREQ: Q8H INFUSE @: 219.64 ML/HR	08 #3 P&T c 3rd dose	16 MJ	24 GS
12-16 12 12-19 11	GS	MAGNESIUM SULFATE 50% (.5G/ML) 65MEQ (435358) NACL 0.9% 250ML FREQ: Q24 INFUSE @: 10.42 ML/HR TO RUN AS CONTINUOUS INFUSION OVER 24HRS X 3 DAYS	12 MJ Day #2		
12-15 08 12-14 07	GS	NACL 0.9% 1000ML (431270) FREQ: Q8H INFUSE @: 125 ML/HR	(8) 1115	(16) 1930 GS	(24)
12-[illegible] [illegible] 12-15 16	GS	OMEPRAZOLE ORAL SUSPENSION 20MG SUSP PO QD (437471) SHAKE WELL	09 MJ		
12/98	GS	Promote @ 15 cc/o 30 Per Protocol Goal 110 cc	1630 compared to 30 MJ	a/bm	
12/17/98	GS	Ampicillin 2gm @ 0600 IV PB		22 GS	04 GS

S	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
	K. Scott RN	MJ	[illegible]		

RMANN HOSPITAL — MEDICATION ADMINISTRATION RECORD

ME: WILFORD, KANE **
CT: 96925490936?
E: 4yr
): DUKE, JAMES H. (T
R: TRAUMA
LERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
AGNOSIS: WOUND OPEN/UNSPEC COMPL

TIC STIC-19
EX: M
GT: 180.34 cm
T: 130.18 kg
BSA:2.46 M2

GENERATED: 12-16-98 11:09pm
FOR PERIOD: 12-17-98 07:00
THROUGH: 12-18-98 06:59
ADMITTED: 12-07-98 12:22am

START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY		07:00-15:00	15:01-23:00	23:01-0
		======== P R N O R D E R S ========				
12-14 15 11-13 14	GS	CHLORPROMAZINE 25MG INJ IM Q6HPRN (AVOID ALCOHOL)	(429635)			
12-11 22 12-19 22	GS	HYDROCODONE W/APAP 5MG/500MG 1TAB TAB PO Q3HPRN 1 - 2 TABLETS AS NEEDED	(422239)			
12-12 12 11-12 11	GS	IBUPROFEN 200MG SUSP NG Q1DPRN (Take with Food)	(425380)	1445 mg	1902 mg	
12-12 10 12-21 09	GS	LORAZEPAM 2MG INJ IV Q2-4HPRN FOR AGITATION (AVOID ALCOHOL) MAY GIVE 2-4MG	(422846)			0010 GS (4 mg)
12-14 13 12-21 12	GS	MORPHINE 2MG INJ IV Q2-4HPRN MAY GIVE 2-10MG	(429029)	1015 mg 4 mg 1330 KC	1446 mg 4 mg 1830 mg	0010 GS (10 mg)
12-14 14 11-13 13	GS	ONDANSETRON 8MG INJ IV Q6HPRN MAY REPEAT Q15MIN IF NO RESULTS TO A MAX OF 32MG	(429016)			
12-12 11 11-11 10	GS	PROMETHAZINE 12.500MG INJ IV Q4-6HPRN FOR NAUSEA AND VOMITING	(423066)			2400 GS
12-12 11 -	GS	TEMAZEPAM 15MG CAP PO PRN 15-30MG FOR INSOMNIA	(423065)			

NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
G. Scott RN	GS		K.T.	Karen D. Lee, RN

ERMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

NAME: WILFORD, KANE **
ACCT: 969254909367
AGE: 24yr
DUKE, JAMES H. (T
E: TRAUMA
ALLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
DIAGNOSIS: WOUND OPEN/UNSPEC COMPL

STIC STIC-19
SEX: M
HGT: 180.34 cm
WT: 130.18 kg
BSA: 2.46 M2

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START / STOP	RECONCILE/ INITIALS	MEDICATION, DOSE, ROUTE, FREQUENCY	07:00-15:00	15:01-23:00	23:01-0
12-17 22 / 12-24 21	GS	AMPICILLIN 2GM NACL 0.9% 100ML FREQ: Q6H INFUSE @: 100 ML/HR (442486)	10	16 22	04
12-14 24 / 12-21 23	GS	CEFEPIME 1GM NACL 0.9% 50ML FREQ: Q8H INFUSE @: 100 ML/HR KEEP REFRIGERATED PROTECT FROM LIGHT (430582)	08	16	24
12-16 16 / 12-23 15	GS	GENTAMICIN 440MG NACL 0.9% 100ML FREQ: Q8H INFUSE @: 219.64 ML/HR (436085)	08	16	24
12-16 12 / 12-19 11	GS	MAGNESIUM SULFATE 50% (.5G/ML) 65MEQ NACL 0.9% 250ML FREQ: Q24 INFUSE @: 10.42 ML/HR TO RUN AS CONTINUOUS INFUSION OVER 24HRS X 3 DAYS (435358)	12 #3	** ORDER STOPS WITHIN 48 HOUR	
1. 08 / 01-14 07	GS	NACL 0.9% 1000ML FREQ: Q8H INFUSE @: 125 ML/HR (431270)	08	16	24 2100
12-16 19 / 01-15 18	GS	OMEPRAZOLE ORAL SUSPENSION 20MG SUSP PO QD SHAKE WELL (437471)	09		
12-17 18 / 01-16 17	GS	PROMOTE OBAG LIQ TF 08 FULL STRENGTH 30CC/HR READY TO HANG (442191)	10	18	02
12/18	JE	Impact TF - same protocol		1700	
12/19	JO	Levoquin 500mg IV Q day		2200	
12/19	JO	Vancomycin 2Gms IV Q12		2100	

INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
GS	G. Scott RN	JE	Janice Ed... RN	M	[illegible]

ERMANN HOSPITAL

MEDICATION ADMINISTRATION RECORD

AME: WILFORD, KANE **
CCT: 969254909367
AG[illegible]24yr
I[illegible]: DUKE, JAMES H. (T
SE[illegible]CE: TRAUMA
ALLERGIES: UNKNOWN PATIENT ALLERGIES
NO KNOWN PATIENT ALLERGIES
DIAGNOSIS: WOUND OPEN/UNSPEC COMPL

STIC STIC-19
SEX: M
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		======== P R N O R D E R S ========				
12-14 15 / 01-13 14	GS	CHLORPROMAZINE 25MG INJ IM Q6HPRN (AVOID ALCOHOL)	(429635)			
12-11 23 / 12-19 22	GS	HYDROCODONE W/APAP 5MG/500MG 1TAB TAB PO Q3HPRN 1 - 2 TABLETS AS NEEDED	(422239)		** ORDER STOPS WITHIN 48 HOURS **	
[illegible]3 12 / 01-12 11	GS	IBUPROFEN 200MG SUSP NG QIDPRN (Take with Food)	(425380)	1330 JE		0315 M
12-12 10 / 12-21 09	GS	LORAZEPAM 2MG INJ IV Q2-4HPRN FOR AGITATION (AVOID ALCOHOL) MAY GIVE 2-4MG	(422846)			
12-14 13 / 12-21 12	GS	MORPHINE 2MG INJ IV Q2-4HPRN MAY GIVE 2-10MG	(429029)	1330(4) JE	1800 JE 2152 M(5)	2311 M(4)
12-14 14 / 01-13 13	GS	ONDANSETRON 8MG INJ IV Q6HPRN MAY REPEAT Q15MIN IF NO RESULTS TO A MAX OF 32MG	(429016)			
12-12 11 / 01-11 10	GS	PROMETHAZINE [illegible].50MG INJ IV Q4-6HPRN FOR NAUSEA AND VOMITING	(423066)	1330(4) JE	1800 JE	
12-12 11 / [illegible] 9 10	GS	TEMAZEPAM 15MG CAP PO PRN 15-30MG FOR INSOMNIA	(423065)		** ORDER STOPS WITHIN 48 HOURS **	

INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE	INITIALS	NAME & PROFESSIONAL TITLE
GS	G. Scott RN	JE	Janace Eborn RN	M	M. Marino MD